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ABSTRACT

This instructional module was designed for certified nurse assistants (CNA). This voluntary training program was developed as a "continuing education" option for the practicing graduate CNA with the intention of providing CNAs with the requisite knowledge and skills to provide care for the confused elderly resident in a long-term care facility. The guide contains eight lesson plans grouped into six units covering the following: overview of dementia, communication, special care needs, family dynamics, stress, and special resources. Each lesson consists of the following components: scope of unit; lesson objectives; information assignment; references; introduction; outline; summary and conclusion; interaction items; classroom/laboratory activities; and evaluation items with answer key. The module also contains a pretest, a posttest, a bibliography, and a resource list. (KC)

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Confused Resident Care

Instructor Guide
50-5080-I

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CONFUSED RESIDENT CARE

Instructor Guide

Produced by the Instructional Materials Laboratory
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PREFACE

In recent years, findings of many research studies have expanded our knowledge of mental confusion in general, and Alzheimer's disease in particular. Organizations such as the Alzheimer's Disease and Related Disorders Association (ADRDA) have contributed significantly by translating current research data into layperson's terms. This knowledge is empowering to victims' families and other caregivers as they learn to cope with the devastating repercussions of mental confusion, especially in such severe disorders as Alzheimer's disease. With the addition of Alzheimer's units to many long-term care facilities, and more families playing an informed and proactive role in the care of their loved ones, additional responsibility is placed on the certified nurse assistant. It is imperative that she or he have not only a clear understanding of the facts about mental confusion and Alzheimer's disease, but competency in providing appropriate care for the confused resident as well. This module provides information and techniques which will train the CNA in this expanded role to respond with compassion, rather than frustration, when faced with the typical behavioral idiosyncracies and nursing care challenges that are presented by the confused resident.

In July of 1988, funds were provided by the Missouri Department of Elementary and Secondary Education for the development of these training materials intended to provide certified nurse assistants with the requisite knowledge and skills to provide care for the confused elderly resident in a long-term care facility. Additional funding the following year allowed for fieldtesting the lesson plans to assure their appropriateness, effectiveness, and usability. Fieldtest/technical review evaluation results were reviewed and necessary final revisions were implemented.

Assistance provided by the ADRDA St. Louis Chapter throughout the development and fieldtest phases of this curriculum project reflected a genuine commitment to their goals of providing family support, increasing education and awareness, supporting research, and promoting changes in public policy necessary to assist victims and families. The ADRDA St. Louis Chapter considers training of certified nurse assistants a high priority and continually demonstrated their support and enthusiasm for this project. Their cooperation in sharing expertise as well as program materials with the writer is gratefully acknowledged.

This voluntary training program was developed as a "continuing education" option for the practicing graduate CNA. There are no state or federal regulations which mandate or regulate training in confused resident care beyond what is presently offered in the basic CNA course (Nurse Assistant in a Long-Term Care Facility, Unit II, Lesson Plan 11 - Dealing With Mental Confusion).

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CONFUSED RESIDENT CARE

Table of Contents

Preface iii

Acknowledgments v

Unit I: Overview of Dementia

Lesson 1 - Myths and Realities of Dementia 1

HO 1: **Alzheimer's Disease** 21

HO 2: **Common Symptoms/Behaviors of AD Residents** 23

HO 3: Normal Forgetfulness vs. AD Memory Loss . . . 25

Unit II: Communication

Lesson 1 - The Attitude Cycle and Communication Skills . 27

HO 1: **Attitude Cycle** 39

HO 2: **Perception Activity** 43

HO 3: **Nonverbal Communication** 45

Lesson 2 - Communication with Alzheimer's Residents . . . 49

HO 1: **Barriers to Communicating with AD residents** . 63

HO 2: **Communicating with AD Residents** 65

HO 3: **Verbal Communication Modifications for Alzheimer's Residents** 67

HO 4: **Nonverbal Communication Modifications for Alzheimer's Residents** 71

HO 5: **Role Playing** 73

Unit III: Special Care Needs

Lesson 1 - Activities of Daily Living 75

Lesson 2 - Behavior Problems 97

Unit IV: Family Dynamics

Lesson 1 - Family Dynamics 117
  HO 1: Working with Families 129

Unit V: Stress

Lesson 1 - Stress Management for the Caregiver 131
  HO 1: Symptoms of Stress 145
  HO 2: Stress Log 147
  HO 3: Techniques for Managing Stress 149

Unit VI: Special Resources

Lesson 1 - Special Resources 151
  HO 1: ADRDA Chapters in Missouri 163
  HO 2: Area Agencies on Aging for Missouri 165
Pretest 167
Posttest 171
Bibliography 181
Resources 185

LESSON PLAN: 1

COURSE TITLE: CONFUSED RESIDENT CARE

UNIT I : OVERVIEW OF DEMENTIA

SCOPE OF UNIT:

This unit will clarify terminology that may have been previously misunderstood and/or misused by the student. Dementia symptomatology specific to Alzheimer's disease will be discussed, as well as the specific behaviors exhibited in the four stages of Alzheimer's disease.

INFORMATION TOPIC: I-1 OR DEMONSTRATION:

MYTHS AND REALITIES OF DEMENTIA
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Identify the definition of dementia.
2. Differentiate between Alzheimer's disease and other types of dementia.
3. Identify common symptoms of Alzheimer's disease.
4. Identify suspected causes of risk factors of Alzheimer's disease.
5. Identify typical behaviors exhibited in each of the four stages of Alzheimer's disease.
6. Recognize the diagnosis, assessment, and treatment for the medical management of Alzheimer's disease.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1.	HO 1:	Alzheimer's Disease
2.	HO 2:	Normal Forgetfulness versus AD Memory Loss
3.	HO 3:	Common Symptoms/Behaviors of AD Residents

INFORMATIONAL ASSIGNMENT: (Student)

Read this lesson prior to class and be prepared to discuss the information presented.

REFERENCES: (Instructor's Additional Information)

Alzheimer's Disease and Related Disorders Association, Inc. Fact Sheet of Alzheimer's Disease. Chicago: ADRDA, Inc. National Headquarters.

Gray-Vickrey, Margaret. Alzheimer's Disease: Coping with Confusion. Hospital Satellite Network and American Journal of Nursing Company. CNE 7501.

Greater New York Hospital Foundation, Inc. Aids and Alzheimer's Disease. A Training Manual for Health-Care Teams about Coping with Chronic and Terminal Illnesses. 1988, (212) 246-7100, p. 44.

Krewson, Jacalyn. Alzheimer's Disease: Teaching Series for Health Care Providers, Instructor's Manual. Pennsylvania Department of Aging, Unit 2.

McDowell and Lincoln. Managing the Person with Intellectual Loss at Home. White Plains, NY: The Burke Rehabilitation Center, 1980.

Riley, Kathryn Perez and Francine Hekelman. Training Home Health Aides in Alzheimer's Respite Care. Cleveland: Alzheimer's Association Cleveland Chapter.

INTRODUCTION:

Alzheimer's disease (AD) was first described by Alois Alzheimer in 1906. AD is a brain disorder that usually affects people over the age of 60, but can also affect people in the 40's and 50's. It is usually a slow process of decline and if the person lives long enough, will probably affect memory and thinking, speech, personality, and self-care abilities. In the very last stages of the disease, the AD resident may become incontinent, unable to talk, and totally dependent on caregivers for all activities of daily living.

LESSON PLAN: 1

COURSE TITLE: CONFUSED RESIDENT CARE

UNIT I : OVERVIEW OF DEMENTIA

OUTLINE: (Key Points)

I. Dementia (II-1)

A. A clinical state with many different causes; usually insidious (gradual, subtle) in onset

B. Characterized by decline from a previously attained intellectual level

C. Arbitrarily measurable in months or years rather than in days or weeks

D. Long lasting in most cases, although some forms of dementia may be arrested or reversed

E. A consequence of dysfunction of the brain, particularly those parts of the cerebrum known collectively as the association areas; this part of the brain integrates perception, thought, and purposeful action so that one can adjust to and survive in the environment

II. Alzheimer's Disease (HO 1)

A. Affects an estimated 2.5 million American adults

B. The most common form of dementing illness

C. More than 100,000 die of Alzheimer's disease annually; AD is the fourth leading cause of death in adults, after heart disease, cancer, and stroke.

D. AD knows no social or economic boundaries and affects slightly more women than men.

E. Most victims are over 65, however, AD can strike in the 40's and 50's.

F. Most AD victims are cared for at home, although many persons in LTC facilities have dementia.

G. AD is devastating for both victims and their families and has been called "the disease of the century."(II-2)

H. Normal aging brings some physical illness or disability and some increase in forgetting people's names or where things are put, but does not involve forgetting one's own past.

I. AD is a physical disease of the brain.

J. AD is not "senility" (senile dementia).

K. AD is not a mental illness.

L. AD affects 15% of the older population.

M. AD is not a normal aging process.

N. AD is only one type of dementia.

III. Symptoms of Alzheimer's Disease

A. AD symptoms and progression present slowly; a gradual deterioration may go unnoticed, unlike multi-infarct dementia which exhibits similar symptoms but has a sudden onset.

B. Symptoms vary in residents; it can be compared to influenza in that some symptoms affect everyone, but how long a symptom lasts and how bad it is varies from individual to individual. (HO 2)

C. Some residents progress quickly through the stages of Alzheimer's disease, while others may live for years without completely deteriorating.

D. Common symptoms

   1. Gradual memory loss (HO 3)

      a. Memory problems and decline in personal self-care may affect all residents.

      b. Other impairments may vary.

   2. Decline in ability to perform routine tasks

   3. Impairment of judgment

   4. Disorientation

   5. Personality changes

   6. Difficulty in learning

7. Loss of language skills

IV. Causes of Alzheimer's Disease (II-3)

A. Suspected causes of Alzheimer's disease identified through research findings include:

   1. Slow virus or other infectious agent

   2. Chromosomal defect

   3. Immunologic changes

   4. Neurotransmitter deficiency

B. Physical factors - no one knows why AD strikes some people and not others

   1. Brain cells die and certain areas of the brain don't function well anymore.

   2. Genetic risk of Alzheimer's disease

      a. A previous proven case in the family increases risk; a proven case means autopsy-confirmed diagnosis of a family member.

      b. Risk factors vary widely based on:

         (1) Other proven cases in the family - risk factor for other family members is .33 percent for the general population.

         (2) Age of onset of the proven case(s) - the earlier the onset the more the risk factor increases for other family members.

         (3) Age of those for whom the risk is being computed - risk factor increases with age.

         (4) First degree relatives are more at risk; these include brothers, sisters, parents, or children of AD victims.

   3. All of us have some risk of getting Alzheimer's disease.

C. Alzheimer's disease **cannot** be caused by:

  1. Cooking with aluminum pots and pans; using aluminum foil for food storage; eating from aluminum tableware or utensils
  2. Stress
  3. Not "using" your memory/being inactive
  4. Injuries to the head

V. Four Stages of Alzheimer's Disease - stages progress from a minor short-term memory loss to a complete loss of bowel and bladder function, memory, and speech; throughout all four stages there is steady mental and physical deterioration.

A. First stage - behaviors exhibited in the first stage include:

  1. Difficulty focusing attention
  2. Decreasing interest in environment and present affairs
  3. Withdrawal from social interaction
  4. Uncertainty in actions
  5. Short-term memory loss
  6. Typical symptoms associated with this stage of disease:
     a. Still living at home and functioning fairly well
     b. Beginning to have trouble driving
     c. Will have difficulty learning complex tasks
     d. Relocation to an acute care setting can make the resident more confused and disoriented.
     e. Resident must have instructions repeated several times and even written down on paper.

B. Stage two - behaviors/symptoms which are seen in the second stage of AD include:

  1. Obvious deficits in memory

2. Hesitation in verbal response

3. Disorientation to time

4. Complains of neglect

5. Forgets appointments and significant events

6. Forgets normal routines

7. Behaviors/symptoms associated with this stage begin to present problems for the caregiver.

    a. Resident may claim that no one has taken care of him/her that day, even though someone has.

    b. Resident often loses money and personal belongings because he/she puts them in a "safe place" but then forgets where it is.

    c. Resident may accuse caregivers of stealing misplaced items.

C. Third stage - involves greater mental deterioration; behaviors commonly seen in this stage include:

1. Disorientation to place

2. Wandering

3. Disorientation to person

4. Deterioration in motor ability

5. Immodesty

6. Communication difficulties (repeating words)

7. Compulsive acts of lip licking, chewing, tapping

8. Mirror signs (resident does not recognize his/her own reflection)

9. Inability to read or write

10. Symptoms associated with this stage can be extremely difficult for caregivers to work with. Residents cannot function alone for many reasons related to safety issues; they need a great deal of assistance from the caregiver.

a. Resident may wander off and not be able to find the way back.

b. Residents often refuse to carry out personal hygiene activities because they either think they have already completed them or the prospect of completing these tasks frightens them.

c. Catastrophic reactions are common. This reaction is a sign that the resident is overwhelmed.

d. Routine activities of dressing, eating, and toileting become difficult, and the resident needs more and more help in all activities.

e. Deterioration continues until the resident is totally dependent upon the caregiver.

D. Fourth stage - the terminal stage; life expectancy after reaching this stage is approximately one year.

1. Incontinence

2. Ataxia - loss of coordination

3. Visual hallucinations

4. Extreme psychomotor retardation

5. Inability to communicate or to recognize family members

6. Little or no response to stimuli

7. Susceptibility to infections

8. Marked weight loss

9. AD residents in the fourth stage require total assistance and continual monitoring.

    a. Resident loses the ability to eat and requires alternate feeding methods.

        (1) Syringe

        (2) N/G tube

        (3) Total parenteral nutrition (TPN)

b. Death usually results from complications due to immobility or respiratory infections.

VI. Medical Management - a working diagnosis of AD is made when all other causes of dementia are ruled out. (II-4)

A. Autopsy diagnosis - there is no single clinical test to identify AD; true diagnosis can only be made when supported by microscopic evidence obtained through autopsy.

1. Neurophysiology of this disorder consists of alterations in the cerebral cortex.

2. Degeneration is found in:

a. Neurofibrillary tangles

b. Senile plaques

c. Atrophy of granulovacuolar cells

B. Diagnosis - there are many disorders that can mimic AD; a very detailed and thorough assessment is essential for every older person with dementia; disorders commonly confused with AD include:

1. Vitamin B_{12} deficiency

2. Iron deficiency

3. Hypoglycemia

4. Infection

5. Hypotension

6. Drug toxicity

7. Adverse drug reactions

8. Fluid and electrolyte imbalances

9. Depression

10. Parkinson's disease

11. Normal pressure hydrocephalus

12. Huntington's disease

13. Multi-infarct dementia (MID) - series of small strokes

14. Brain tumors

C. Medical assessment should include:

1. Complete history and physical examination
2. Detailed neurological examination
3. Psychiatric/mental status examination
4. Nutritional assessment including a three-day calorie count and nutritional analysis
5. Family history
6. Review of all medications, including over-the-counter medications

D. Laboratory studies - complete work-up should include

1. Complete blood count
2. Urinalysis
3. Serum glucose
4. Fasting blood sugar
5. Serum electrolytes
6. Blood urea nitrogen
7. Creatinine
8. Thyroid function studies
9. Liver function studies
10. Digitalis and barbiturate levels
11. Vitamin B_{12} and folic acid levels
12. VDRL (Venereal Disease Research Laboratory) test

E. Diagnostic studies that should be included are:

1. Chest x-ray
2. EKG

3. Skull x-ray

4. CAT scan

F. Treatment of Alzheimer's disease

1. No cure is available at the present time. (II-5)

2. Good planning and medical and social management can ease the burden on the resident and family.

3. Physical exercise and social activity are important as well as proper nutrition and health maintenance.

4. A calm and well-structured environment may help the afflicted person to maintain as much comfort and dignity as possible.

VII. Summary and Conclusion

A. Dementia

B. Alzheimer's disease

C. Symptoms of Alzheimer's disease

D. Research findings concerning suspected causes of Alzheimer's disease

E. Four stages of Alzheimer's disease

F. Medical management

Alzheimer's disease is exactly that--a disease. AD victims have brain damage. They are not purposely acting like children--they are simply no longer capable of controlling their behavior. They do things that they would never have done before. Caregivers must accept the effects of this disease, and still treat residents with dignity and care even on their most unlovable days, which are the times when they most need concerned care and understanding.

LESSON PLAN: 1

COURSE TITLE: CONFUSED RESIDENT CARE

UNIT I : OVERVIEW OF DEMENTIA

INTERACTION ITEMS:

1. How would you define the term dementia?
2. Why is Alzheimer's disease so devastating to the family?
3. What are some causes of Alzheimer's that you have heard about?
4. Why do you think AD is so difficult to diagnose?
5. How can we best meet the needs of the Alzheimer's resident in light of the fact that he/she is incurable and will only get worse?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Have the class divide into small groups (2 or 3 in each group) and discuss their personal experiences with AD residents. Suggest that they may compare observations and experiences of working with residents and what happens as residents progress through the four stages of Alzheimer's disease.

LESSON PLAN: 1

COURSE TITLE: CONFUSED RESIDENT CARE

UNIT I : OVERVIEW OF DEMENTIA

EVALUATION ITEMS:

For each of the following, write "T" if the statement is true or "F" if it is false.

____ 1. Dementia means the same thing as Alzheimer's disease.

____ 2. Dementia is characterized by a decline from a previously attained intellectual level.

____ 3. Dementia is usually long lasting in most cases, although some forms of dementia may be arrested or reversed.

____ 4. AD affects an estimated 2.5 million American adults.

____ 5. AD is the most common form of dementing illness.

____ 6. AD is the fourth leading cause of death in adults.

____ 7. AD is a normal part of aging.

____ 8. AD is a physical disease of the brain.

____ 9. AD is a mental illness.

____10. With AD, memory problems and decline in personal care may affect all residents.

____11. With AD, memory loss is sudden in onset.

____12. The resident with AD will experience personality changes, difficulty in learning, loss of language skills.

____13. Some of the suspected causes of Alzheimer's disease are slow virus, chromosomal defect, immunologic changes, neurotransmitter deficiency.

____14. A family history of Alzheimer's disease presents a decreased risk factor for family members.

____15. Multi-infarct dementia is characterized by slow onset.

____ 16. Cooking in aluminum pots and using aluminum foil causes AD.

____ 17. In the first stage of AD the resident may exhibit difficulty focusing attention.

____ 18. In the first stage of AD the resident may withdraw from social interaction.

____ 19. Loss of short-term memory is exhibited in the first stages of AD.

____ 20. The AD resident in the first stage is usually still living at home and functional.

____ 21. In the second stage of AD the resident will exhibit obvious deficits in memory.

____ 22. Hesitation in verbal responses is exhibited in the second stage of AD.

____ 23. An AD resident complains that no one has taken care of him all day when, in fact, you have spent several hours throughout the day providing care for the resident. This behavior is characteristic of the second stage of AD.

____ 24. An AD resident is disoriented to place and person, has a decrease in motor skills, and is frequently found wandering. This resident is demonstrating behavior commonly exhibited in the third stage of the disease.

____ 25. In the third stage of AD, the resident may not recognize his or her own reflection in the mirror.

____ 26. Catastrophic reaction is common in stage three.

____ 27. Stage four is the terminal stage of AD.

____ 28. An autopsy is NOT the only way to correctly diagnose Alzheimer's disease.

____ 29. No other diseases mimic Alzheimer's disease.

____ 30. There is no cure for Alzheimer's disease.

____ 31. Good planning and medical and social management can ease the burdens on the resident and family.

____ 32. Physical exercise and social activities are NOT recommended for the AD resident.

____ 33. A calm and well-structured environment helps AD residents retain their comfort and dignity.

LESSON PLAN: 1

COURSE TITLE: CONFUSED RESIDENT CARE

UNIT I : OVERVIEW OF DEMENTIA

ANSWERS TO EVALUATION ITEMS:

1. F
2. T
3. T
4. T
5. T
6. T
7. F
8. T
9. F
10. T
11. F
12. T
13. T
14. F
15. F
16. F
17. T
18. T
19. T
20. T
21. T
22. T
23. T
24. T
25. T
26. T
27. T
28. F
29. F
30. T
31. T
32. F
33. T

ALZHEIMER'S DISEASE

- DISEASE OF THE BRAIN
- MEMORY LOSS
- PROGRESSIVE
- CERTAIN CAUSE IS NOT KNOWN
- AFFECTS MORE FEMALES
- LIFE EXPECTANCY AFTER DIAGNOSIS IS 2-20 YEARS
- FOURTH LEADING CAUSE OF DEATH IN ADULTS

COMMON SYMPTOMS/BEHAVIORS OF AD RESIDENTS

1. Memory loss; inability to learn new things; inability to concentrate
2. Conversational and social skills deteriorate
3. Time orientation is impaired
4. Ability to do simple math or calculations diminishes
5. Lack of judgment
6. Suspiciousness
7. Restlessness/wandering
8. Personality changes/mood swings
9. Insomnia/sleep disturbances

HO 3

NORMAL FORGETFULNESS VS. AD MEMORY LOSS

THE RESIDENT WITH NORMAL FORGETFULNESS . . .	THE RESIDENT WITH ALZHEIMER'S DISEASE . . .
Forgets details of a recent experience, but not the experience itself	Forgets recent experiences
Frequently remembers a forgotten item later	Is not aware that he/she has forgotten anything
Can use notes, reminders to refresh memory	Cannot use notes, or other cues to aid recall
Can recognize people and places, even if he/she cannot recall their names	Gradually does not recognize names, persons, or places
Can follow both written and/or spoken directions	Eventually cannot follow written or spoken directions
Knows time of day	Gradually becomes disoriented, even to season of year

LESSON PLAN: 1

COURSE TITLE: CONFUSED RESIDENT CARE

UNIT II : COMMUNICATION

SCOPE OF UNIT:

This unit will review basic communication skills in an attempt to improve communication between the resident, the family, and the nursing staff. Modifications necessary to improve verbal and nonverbal communication with the confused resident will also be discussed.

INFORMATION TOPIC: II-1 OR DEMONSTRATION:

THE ATTITUDE CYCLE AND COMMUNICATION SKILLS
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. List the four stages in the attitude cycle.
2. Identify the influence of perceptions on communication between the resident, the resident's family, and members of the nursing staff.
3. State the percentage of a message that is communicated through nonverbal body language.
4. List categories of nonverbal communication and give an example of each.
5. List verbal feedback responses that indicate good listening skills.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Attitude Cycle
2. HO 2: Perception Activity
3. HO 3: Nonverbal Communication

INFORMATIONAL ASSIGNMENT: (Student)

Nurse Assistant in a Long-Term Care Facility. Columbia, MO: Instructional Materials Laboratory, University of Missouri - Columbia, rev. 1987. Review Unit I, Lesson Plan 5, "Communication Skills."

Read Lesson 1 prior to class and be prepared to discuss the information presented.

REFERENCES: (Instructor's Additional Information)

Allaire, Barbara and Robert McNeil. Teaching Patient Relations in Hospitals, the Hows and Whys. American Hospital Publishing, Inc., AHA, 1983, pp. 61-138. AHA catalog no. 049150.

Krewson, Jacalyn. Alzheimer's Disease: Teaching Series for Health Care Providers, Instructor's Manual. Pennsylvania Department of Aging, Unit 2.

Greater New York Hospital Foundation, Inc. AIDS and Alzheimer's Disease. A Training Manual for Health-Care Teams about Coping with Chronic and Terminal Illnesses. 1988, p. 44.

Nurse Assistant in a Long-Term Care Facility. Columbia, MO: Instructional Materials Laboratory, University of Missouri - Columbia, rev. 1987.

INTRODUCTION:

Communication. We do it every day. We talk, listen, and observe, but do we do it well? Any police officer will tell you that if there are five witnesses at an accident scene, there will be five different versions of how the accident happened. There are many reasons for this conflict between perception and reality, and today we will be reviewing some of them. The attitudes of the listener and sender affect what is heard as well as the verbal and nonverbal messages that are transmitted.

LESSON PLAN: 1

COURSE TITLE: CONFUSED RESIDENT CARE

UNIT II : COMMUNICATION

OUTLINE: (Key Points)

NOTE: Take a few minutes to review Unit I, Lesson Plan 5 of the Nurse Assistant manual - "Communication Skills" to refresh the students on topics such as the five elements of communication, etc.

I. Attitude Cycle (HO 1)

   A. Attitude - the way you feel about something; influences your perception (II-1)

   B. Perception - the way you interpret something; influences the way you act toward it (positively or negatively) (II-2)

   C. Action - your behavior in a particular situation; influences the end result (II-3)

   D. Result - the outcome of the interaction; reinforces the original attitude (II-4)

II. How Perception Affects Communication (HO 2)

NOTE: Use Handout 2 and Classroom Activity 3 to prepare students for the following information about how perceptions vary from person to person.

   A. Perceptions of those involved in the communication process can enhance, complicate, or prevent communication.

   B. Perception can vary with a person's role or involvement in a particular situation.

   C. Role-related perceptions that may impede communication in the LTC facility:

      1. Resident's perception of the LTC facility (II-5)

         a. Feelings about being admitted

         b. Feelings about the LTC facility being his/her last home

        - c. Perceptions that may be distorted due to confusion

    2. Family's perception of the LTC facility (II-6)

        - a. Feelings about "turning over" a family member to strangers who see her/him as "just another resident" (may be dealing with guilt)
        - b. Feelings of helplessness when confronted with the effects of aging and dementia in a parent or spouse (may be dealing with fear)
        - c. Feelings about the LTC facility as a place where their loved one's needs may not be properly met (may be dealing with doubt)
        - d. Feelings of financial distress due to the cost of institutionalization of their loved one

    3. Staff members' perceptions of the resident, the resident's family, and other staff members (II-7)

        - a. Viewing the resident as "another admission" that will require more time and energy from an already overburdened staff
        - b. Viewing the new resident who is diagnosed as Alzheimer's or related disease as a compounded problem
        - c. Viewing the resident's family as troublesome or meddling, or the other extreme of totally detached and uncaring
        - d. Dealing with conflicts that may possibly occur between members of the staff or supervisory personnel

D. Always try to be aware of how someone's perception (yours and/or the other person's) may be creating a barrier to communication

III. Nonverbal Communication (Body Language)

A. 80% of our perception of a message can be attributed to nonverbal communication.

B. Our body language must be consistent with our verbal communication.

C. Avoid using nonverbal signals that could be misinterpreted.

D. Types of nonverbal communication and possible interpretations (II-8)

NOTE: Refer to Handout 3 for more information on the following types of nonverbal communication.

1. Eye behaviors
2. Gestures
3. Touching
4. Posture
5. Physical distance
6. Head behaviors
7. Facial expression
8. Vocal qualities
9. Environment

IV. Listening Skills (II-9)

A. Nonverbal listening skills

1. Face speaker standing at a comfortable distance
2. Lean forward slightly
3. Establish good eye contact

B. Verbal feedback responses

NOTE: Inform students that these responses are appropriate for use with nearly everyone BUT the AD resident. Refer to the next lesson for specific techniques for communication with Alzheimer's disease residents.

1. Ask questions to clarify what the speaker is trying to communicate.
2. Comment briefly on something the speaker said to show him/her that you are paying attention.
3. Use phrases that show interest and encourage the speaker to open up such as, "go ahead" or "tell me

more about that."

4. Paraphrase by reflecting back to the speaker in your own words what you understood him/her to say and thus create the opportunity for correction in case you misunderstood.

5. Empathize by putting yourself in the speaker's place to try to better understand his/her feelings and say "I understand how you must feel," or "I imagine that must make you feel very frustrated."

C. A good listener should not:

1. Interrupt the speaker

2. Offer advice or solutions until you have listened, and unless it is asked for or is part of your job

3. Get off the track by telling your story when the speaker needs to tell his/her story

4. Morally judge the speaker

5. Deny what the speaker is feeling; Example: "Oh, don't be upset." or "Calm down, there's nothing to worry about." or "You shouldn't feel that way."

V. Summary and Conclusion

A. Attitude cycle

B. How perception affects communication

C. Nonverbal communication (body language)

D. Listening skills

It is not possible to completely understand the communication process after one brief lesson. Many people make it a lifelong study. Any time you are attempting to change a behavior, it takes consistent practice before change can occur. Many problems at work and at home are related to communication problems. This is even more so when dealing with a resident with dementia. Nonverbal communication is the "background music" of all face to face interaction. It is the most important element of communication, for it shapes the meaning of verbal messages. It is crucial to understand the primary importance of nonverbal communication to successfully communicate with the normal resident or the resident with dementia.

LESSON PLAN: 1

COURSE TITLE: CONFUSED RESIDENT CARE

UNIT II : COMMUNICATION

INTERACTION ITEMS:

1. How do you feel about paying taxes?
2. Do you see paying taxes as a positive or negative event?
3. How many wait until the last minute to mail your taxes?
4. How many feel you do not get an acceptable refund?
5. How do you think some of the residents feel when they are admitted to a long-term care facility?
6. How do you think the family feels when they have to place a loved one they have been caring for at home in a long-term care facility?
7. How do you as a staff member feel when you are receiving a new resident with the diagnosis of Alzheimer's or a related disease?
8. What are some examples of nonverbal communication?
9. Do you know someone who is a good listener? How do you feel after communicating with that person?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Ask participants to give examples of how their attitude cycle affects their job with regard to interactions and communication with residents, residents' family members, other staff. This should be discussed in an informal way, as some participants may be hesitant to reveal their attitudes and perceptions and should not be forced to participate if they are uncomfortable.
2. Refer participants to Handout 2 (Perception Activity) and ask each to study the picture for a few minutes. Then ask the group what they saw in the picture. Some will say they saw a young woman, and others will see an old woman. Have participants help each other until every person can see both women. Point out that this is an exercise in helping someone to see something from a different perspective.
3. Take turns demonstrating nonverbal behaviors discussed in Handout 3.

LESSON PLAN: 1

COURSE TITLE: CONFUSED RESIDENT CARE

UNIT II : COMMUNICATION

EVALUATION ITEMS:

1. List the four stages in the attitude cycle.

   a.

   b.

   c.

   d.

For each of the following, write "T" if the statement is true, or "F" if the statement is false.

____ 2. Perceptions of those involved in the communication process can complicate communication if they are in conflict.

____ 3. The resident's perception of the LTC facility will always have a positive effect on his/her communication with the nurse assistant.

____ 4. Difficulty in communicating with the resident's family may stem from their feelings of guilt at having to turn over their loved one to "strangers" for care.

____ 5. The nurse assistant may perceive the resident who has been diagnosed as Alzheimer's in a more positive light than the "normal" resident.

____ 6. If you cannot communicate with someone it is most likely because the other person's perception is wrong.

7. The amount of communication that is relayed nonverbally is estimated to be: (Circle the letter of the best answer.)

   a. 50%
   b. 75%
   c. 80%
   d. 100%

8. List two categories of nonverbal communication and give an example of each.

a.

b.

9. List four verbal feedback responses that indicate good listening skills.

a.

b.

LESSON PLAN: 1

COURSE TITLE: CONFUSED RESIDENT CARE

UNIT II: COMMUNICATION

ANSWERS TO EVALUATION ITEMS:

1. a. Attitude
   b. Perception
   c. Action
   d. Result
2. T
3. F
4. T
5. F
6. F
7. c
8. The student may list any two of the following in any order. The examples are to be evaluated according to the instructor's criteria.
   a. Eye behavior
   b. Gestures
   c. Touch
   d. Posture
   e. Physical distancing
   f. Head behaviors
   g. Facial expression
   h. Vocal qualities
   i. Environment
9. The student may list any two of the following in any order.
   a. Asking questions
   b. Commenting briefly
   c. Using phrases that show interest
   d. Paraphrasing
   e. Empathizing

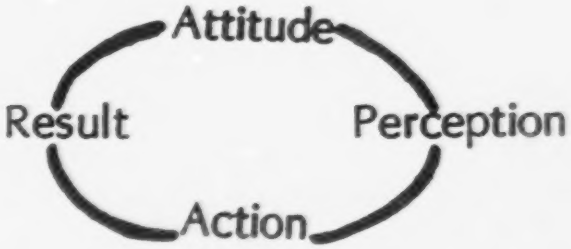
ATTITUDE CYCLE

An attitude is the way you feel about something. Some examples of attitude are: "I am anxious about math."; "I love my job."; or "I am intimidated by those in authority, like doctors." Attitudes come to us from many sources. They may be taught to us from babyhood by our parents or others close to us such as an attitude of respect (or fear) for persons of authority. Your attitude about something may be part of the general attitude in your own culture such as thinking that one who arrives late without an explanation is discourteous. Attitudes may come from particular personal experiences you have had, for example, fearing all dogs after having been bitten by a dog.

How attitudes work . . .

You have attitudes about much of your world which constantly influence the way you perceive or interpret something. For example, if you are anxious about math (an attitude), every math problem you face looks too complicated and overwhelming (a perception based on attitude). The way you perceive something often influences the way you act toward it. For example, if the math problem appears to be overwhelming (a perception), you will have trouble concentrating on figuring it out (action). The way you act toward something influences the result. For example, if you have trouble figuring out the math problem (action), you may get it wrong (result). This result then reinforces your original attitude. For example, if you cannot correctly solve a math problem, you become even more anxious about math.

This example of "math anxiety" illustrates the attitude cycle. Attitude influences perception, which in turn influences action, which in turn influences the result, which in turn influences the original attitude. Because of the very nature of the attitude cycle, attitudes get continual reinforcement.



So, how does the attitude cycle show itself in the long-term care facility? Here is an example.

Susan (the nurse assistant) is exhausted and irritable when she gets ready for work on Monday morning. (attitude) On the way to work she remembers how hard she worked last week, and is anticipating how demanding and difficult the charge nurse will be when she arrives at work today. (perception) The charge nurse is standing at the front desk with her hands on her hips, a frown on her face, and her forehead all wrinkled up. The first words out of her mouth when she sees Susan come in are, "Hurry up and get that stuff put away! The shift hasn't even started yet and we are already behind!"

Susan replies, "My shift doesn't start for half an hour. I came in early so I could have a cup of coffee and relax a little before this day starts." (action) The charge nurse then says, "Look, you don't have time to sip coffee! You know how busy we were last week with one NA on vacation and one sick. Well, that's nothing compared to this week. We have three more residents than we did last week, and you have to get moving now!"

Susan snaps back, "No! My shift starts at 7:00 a.m., and I am not starting one minute before that. I remember all the extra work I did last week, and all I got from you was complaining because I didn't do more." The charge nurse, who by now is furious says, "If you don't start to work right now, you won't have a job!" (result)

The attitude cycle has made Susan's original attitude of annoyance even stronger. Now she is not simply annoyed, she is very angry and feeling even worse about being at work. The charge nurse has her own attitude cycle in motion which makes the matter even more complex.

Breaking the attitude cycle . . .

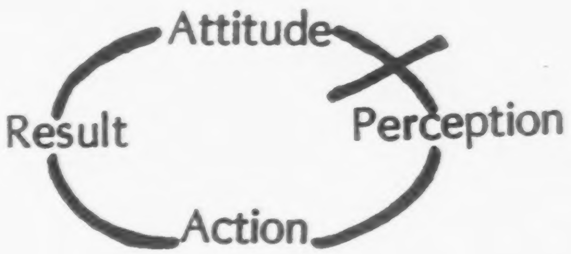
It helps to be aware of what your present attitude is in a given situation and how you got that attitude. In the above example, the nurse assistant's feelings of exhaustion and irritability could be the result of a stressful weekend at home combined with the typical Monday morning "blahs" we all experience to some degree. Also, her previous experiences with the charge nurse are causing her to have negative feelings about her job. Once Susan recognizes the attitude she is bringing to her work situation, she is in a better position to evaluate her perceptions of the workplace, especially knowing that the way she sees a person or situation may be colored inaccurately by her attitudes.

When Susan recognizes the source of her negative attitude, she may then be able to pause a few seconds to reconsider her

40

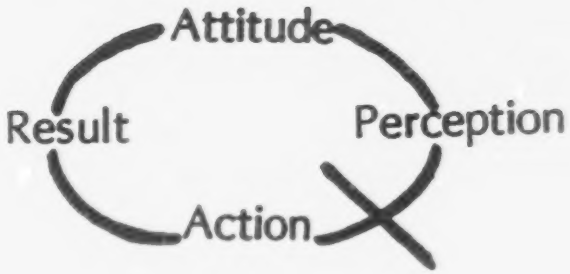
perception before taking action. For example, in this same situation Susan could think, "The charge nurse looks really tense already this morning. Maybe someone else is sick or absent today, or a resident is in crisis." Then, when the charge nurse begins to urge her to get busy, Susan might respond by saying, "You look like there are some major problems already this morning, what's going on ?"

The charge nurse then might say, "You bet! We still are two short on staff, we have had three admissions, and the day has not even started yet." Susan could respond by saying, "I'll put my things away and grab a cup of coffee; then let's look at our situation and see how we can deal with it. We made it last week, didn't we? It wasn't easy, but we will make it this week too." In this example, Susan has broken a negative attitude cycle between attitude and perception.



Susan's revised perception of her supervisor has helped her to act in a positive, constructive way. The result is that the charge nurse will probably accept Susan's help and will be less anxious (and critical) for the rest of the day. The charge nurse may also have a new respect for Susan because she stayed in control when the charge nurse did not. Now the nurse assistant feels she is doing something worthwhile; she is supporting her supervisor and making things a bit easier for both of them.

The best place to break a negative attitude cycle is between the attitude and the perception. If you have tried unsuccessfully to change your attitude or your perception in a given situation, what then? Maybe your perception is a correct one. Maybe this individual is every bit as hostile as you think he or she is. Your perception may be right, but you can carefully consider your action to avoid adding to the hostility or making yourself a victim. Focus on breaking the attitude cycle between the perception and the action.



By responding in a low-key, helpful way, you may decrease the other person's hostility. Perhaps just the knowledge that people come into a situation with their own attitude cycle operating will help you to better understand them and then alter your actions in a positive way.

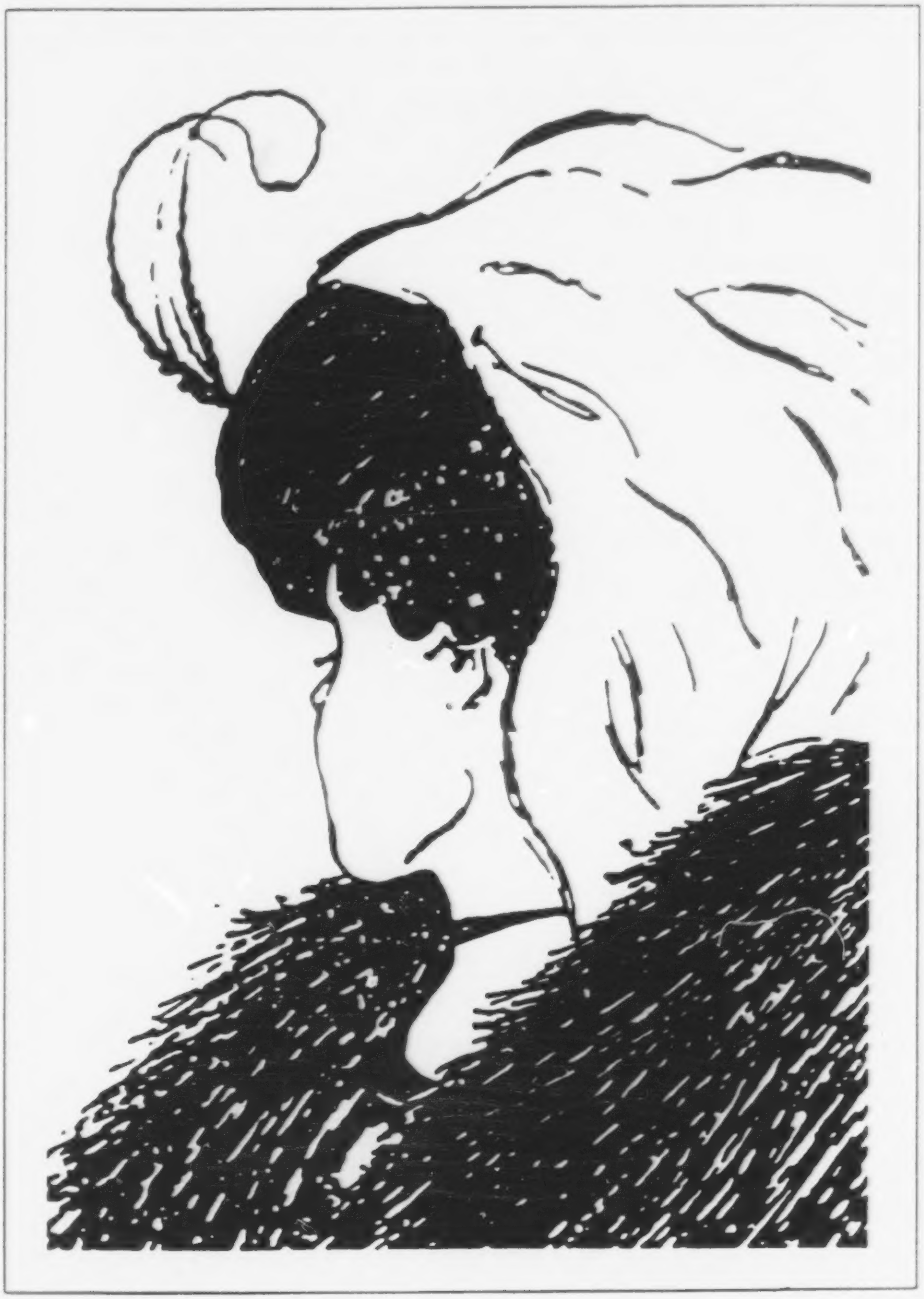
The attitude cycle exists everywhere . . .

The attitude cycle is an amazing thing. You may begin to see it operating everywhere. Have you noticed that emotionally disturbed residents become more upset and sometimes violent when surrounded by staff who are visibly afraid of them? Or how children whose parents say in a threatening way, "You better be good!" tend to misbehave? The attitude cycle also explains how you become the life of the party when the other guests happen to think you have the world's greatest sense of humor.

Whenever you seem to be getting just what you expect (whether in the positive or negative sense), think about your attitude cycle. Experiment a little by consciously adjusting your attitude to be more positive and then wait for the positive results that are sure to follow.

PERCEPTION ACTIVITY

(For Use With Classroom Activity #2)



NONVERBAL COMMUNICATION

Nonverbal communication is the "background music" of all face to face interaction. In that sense, it is the most important element of communication, for it shapes the meaning of verbal messages. The impact of nonverbal communication on messages you send and receive is powerful.

The following chart contains examples of various types of nonverbal communication or "body language" that will inevitably occur in any communication exchange. Study it well so that you can become aware of subtle messages you are sending and receiving during the communication process with residents, residents' family members, and other staff members.

TYPES	EXAMPLES	INTERPRETATIONS
Eye Behaviors	Steady, warm	I'm listening (or I like you)
	Staring	You're weird (or I don't like you)
	None or fleeting	I'm bored; you're not really worth my time (or I'm anxious or I'm resistant)
	Peering over glasses	I'm skeptical
	One eyebrow raised	I disapprove (or I don't believe you)
Gestures	Drumming finger, tapping pencil	Hurry up, I'm impatient (or you bother me)
	Clenched fist	I'm angry (or I'm tense)
	Relaxed, open hands	I'm open to you (or I feel relaxed)
	Pointing finger	I'm blaming you (or now, you listen to me)

Touching	Firm hand on another's hand, arm, or shoulder	I care about you (or I feel you are important)
	Lack of touching	I want to keep my distance
Posture	Facing other person	I like you (or I'm being straight with you)
	Turning away from other person	I want to avoid you
	Slouched	I'm relaxed (or I don't take this conversation seriously)
	Erect	I'm on edge (or I take this conversation very seriously)
	Leaning forward	I'm interested
	Leaning backward	So what?
	Uncrossed arms and/or legs	I like you (or I'm feeling relaxed)
	Crossed arms or legs	I don't like you (or I'm feeling defensive)
Physical distancing	Closeness	I feel friendly (or I'm feeling aggressive)
	Far away	I feel distant (or I feel superior)
	Above the other	I am superior
	Below the other	I am beneath you
	At the same level	We are equals
Head behaviors	Nodding	I agree (or I understand)
	Head shaking	I disagree (or I'm confused)
	Cocking head to one side	I doubt it (or I'm amused, or I'm listening intently)

Facial expression	Smile	I like you (or I want your approval)
	Frown	I'm confused (or I don't like this or I don't like you)
	Clenched teeth	I'm tense (or I'm feeling threatened)
	Open mouth	I'm relaxed (or I'm surprised or in wonder)
	Curled lip	I'm disgusted (or I'm mocking you)
Vocal qualities	High pitch	I'm nervous (or I'm angry, or I don't really believe in myself)
	Low pitch	I'm confident
	Softness	I feel affection (or I'm afraid of offending anyone)
	Monotone	I'm bored
	Cracked voice	I'm nervous (or I'm afraid)
Environment*	Keeping someone waiting	I'm in control
	Desk or barrier between one person and the other	I keep you at a distance
	No barrier	I feel open toward you
	Comfortable lighting, furnishings	I am a warm person

*The setting in which communication occurs, including time elements, room color, lighting, attractiveness of furnishings, furniture arrangement

Remember, experts who study communication have found that 80% of our liking another person is attributable to nonverbal messages that person sends. This means that much is being communicated without words. In fact, you are always communicating something to those around you with your body, if not with your words.

When the message you send in words does not match the message that your body is sending, there is obvious inconsistency. This can be confusing or irritating to the receiver. Which message, verbal or nonverbal, do you think the receiver will believe? The nonverbal, of course. Think of the possible ways to say the words, "I really care about you." The way the words are said is really more important than the words themselves. Perhaps nonverbal communication is believed more readily because it is not subject to the kind of control you can put on words. You may not even be consciously aware that nonverbal signals from another person are bothering you; you are just vaguely aware that no matter what the other person says, you are uncomfortable or skeptical or angry, and you do not know why. You may even blame it on yourself.

The difficulty with nonverbal communication, though, is that it is also easier to misinterpret than verbal communication. No doubt you have read more into another's grunt or slouch or stare than was really there. It is very important that you weigh the combination of verbal and nonverbal communications before making a judgment of the communicator based on one or the other.

Sensitivity to nonverbal cues in others is a skill you can develop, just through awareness and careful monitoring of your own "nonverbals." Remember, you cannot become an instant "body language expert," but it helps to know the fundamentals and apply them to your own interactions.

LESSON PLAN: 2

COURSE TITLE: CONFUSED RESIDENT CARE

UNIT II: COMMUNICATION

SCOPE OF UNIT:

This unit will review basic communication skills in an attempt to improve communication between the resident, the family, and the nursing staff. Modifications necessary to improve verbal and nonverbal communication with the confused resident will also be discussed.

INFORMATION TOPIC: II-2 OR DEMONSTRATION:

COMMUNICATION WITH ALZHEIMER'S RESIDENTS
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Name barriers to communicating with residents with Alzheimer's disease.
2. List environmental considerations which could enhance communication with the AD resident.
3. List ways verbal communication should be modified when communicating with the confused resident.
4. List ways nonverbal communication should be modified when communicating with the confused resident.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Barriers to Communicating with AD Residents
2. HO 2: Communicating with AD Residents
3. HO 3: Verbal Communication Modifications for Alzheimer's Residents
4. HO 4: Nonverbal Communication Modifications for Alzheimer's Residents
5. HO 5: Role Playing

INFORMATIONAL ASSIGNMENT: (Student)

Read this lesson prior to class and be prepared to discuss the information presented.

REFERENCES: (Instructor's Additional Information)

Alzheimer's Disease and Related Disorders Association, Inc. Home Care with the Alzheimer's Patient. ADRDA, Chicago, IL, 1988, pp.8-9.

Krewson, Jacalyn. Alzheimer's Disease: Teaching Series for Health Care Providers, Instructor's Manual. Pennsylvania Department of Aging, Unit 2.

Greater New York Hospital Foundation, Inc. AIDS and Alzheimer's Disease. A Training Manual for Health-Care Teams about Coping with Chronic and Terminal Illnesses. 1988, (212) 246-7100, p. 44.

American Journal of Nursing Company and Hospital Satellite Network. Alzheimer's Disease: Coping with Confusion. #7501, 1985.

Hospital Satellite Network and UCLA Extension, Alzheimer's Disease: Effects on Communication. #8347, 1986.

Alzheimer's Diseases and Related Disorders of Cape Cod and the Islands/Eastern Massachusetts/Western Massachusetts, Family Care Guide. ADRDA, pp. 33-38, 1988.

INTRODUCTION:

In the last lesson we reviewed communication. Communication is an exchange between two people using words (verbal) and body language (nonverbal).

Communicating with the resident, the resident's family, and staff is important. It is a skill that becomes better with practice. Communicating with Alzheimer's disease residents is the key to successfully caring for them; however, it is frequently difficult. This lesson focuses on ways of exchanging information (communicating) with Alzheimer's disease residents.

LESSON PLAN: 2

COURSE TITLE: CONFUSED RESIDENT CARE

UNIT II: COMMUNICATION

OUTLINE: (Key Points)

I. Barriers to Communication with AD Residents (HO 1)

(II-1)

   A. Brain damage

      1. Intellectual impairment - resident fades in and out of the conversation; is not in continuous touch with reality

         a. Thoughts are not logical

         b. Unable to maintain a cohesive thought pattern

      2. Comprehension - resident may be able to read or listen attentively, but cannot attach meaning to the content of what is read/heard

         a. Thought patterns are not cohesive

         b. Has difficulty comprehending two compatible acts (wash your hands and face)

   B. Memory loss

      1. Short-term memory loss - resident does not remember what happened seconds before, therefore, he/she cannot understand the present moment

      2. Resident is not capable of communicating normally (cannot remember what he/she wanted to say)

      3. Resident may communicate verbally in a routine, superficial conversation (How are you? I am fine.) simply because he/she has practiced this exchange for many years and it is an automatic response; does not indicate that the resident is consciously communicating

II. Environmental Considerations Affecting Communication

   A. Before attempting to communicate with the resident, minimize environmental stimuli by eliminating distracting background noises.

B. Before any attempt to communicate with the AD resident (verbal or nonverbal), be sure the resident who needs a hearing aid and/or glasses is wearing them.

C. Never use the intercom system to communicate with an AD resident or to communicate with others when you are in the presence of the AD resident. This increases the resident's confusion. They do not know where the voice is coming from and it could increase hallucinations.

D. Communication may be enhanced in rooms that are bright and cheerful.

III. Verbal Communication (HO 2, HO 3)

A. Words actually play a minor role in communicating with the AD resident; as the disease progresses, verbal communication becomes less and less effective.

B. Key points of verbal communication with the AD resident:

1. Vocal qualities (II-2)

a. Do not whisper - whispering may make the AD resident suspicious, or nearby residents may wonder what is being said about them

b. Do not shout - if the AD resident cannot understand what you are communicating, shouting at him/her will not help--it will be perceived as threatening

c. Speak slowly and at a low pitch - this type of speaking voice is what older adults hear best

d. Modulate your voice so that it is quiet and calm - AD residents can perceive impatience, and this may cause them to become belligerent and angry

2. When asking questions:

a. Ask questions that are short and simple.

b. Keep questions direct and to the point.

c. Ask just one question at a time.

- d. Repeat a question exactly as asked the first time; AD residents think slowly, and when questions are changed or words are added, it will take them longer to understand and respond.

3. When making brief comments:

   - a. Repeat a comment or command exactly as stated the first time. AD residents think slowly, and when sentences are changed or words are added, it takes them longer to understand and respond.
   - b. Give positive instructions, avoiding saying "don't" or giving negative commands.
   - c. Always get a resident's attention by calling his/her name. AD residents continue to respond to their name during much of the disease.
   - d. As soon as eye contact is made, begin speaking to the resident. The AD resident's attention span may last only a few seconds.
   - e. Avoid the use of pronouns by making direct references to persons and objects. Telling the resident to "Get it." is confusing. Instead, tell him/her to "Get the washcloth."

C. Use an appropriate style of communication (II-3)

1. Use phrases that show interest

   - a. As you speak, also remember to convey the intended message with body language.
   - b. While speaking or gesturing, establish and maintain eye contact with the resident to show interest.
   - c. Use appropriate gestures (such as nodding your head to express approval and encouragement) that will reinforce what you are saying.

2. Avoid paraphrasing

   - a. Totally eliminate the tendency to rephrase sentences.

b. Repeat a request or statement word for word, exactly as stated the first time.

3. Remember to empathize

a. Convey empathy primarily with body language.

b. Do not clutter a message with more words than needed to convey meaning.

IV. Nonverbal Communication (HO 2, HO 4)

A. Comprises more than 80% of communication with the AD resident.

B. No matter how advanced AD is, or how much difficulty residents have with words, they do have the ability to interpret body language.

C. Key points of nonverbal communication with the AD resident: (II-4)

1. Eye behaviors - make eye contact before speaking; maintain eye contact throughout your interaction with the AD resident

2. Gestures

a. Exaggerate your gestures.

b. Be sure your gestures and body movements are compatible with your words.

c. Make sure your gestures are calm and gentle no matter what your personal feelings are.

d. Be consistent with the gestures you use with a specific resident. Use the same gesture to express the same idea each time you communicate with him/her.

e. Demonstrate to the resident what you are trying to communicate to him/her.

3. Touching

a. Touch the resident gently to convey your caring attitude and get his/her attention.

b. Caution: AD residents may interpret your touch as threatening; do not take it personally.

4. Posture

   a. Position yourself at the same level as the resident.

   b. If you are at a higher level than the resident, he/she may feel threatened.

5. Physical distance

   a. Position yourself 1 to 1 1/2 feet from the resident initially, and adjust the distance gradually.

   b. Caution: resident may feel threatened even at this distance so be prepared to adjust by moving back from the resident.

6. Head behaviors

   a. Exaggerate the movements of your head.

   b. Your head movements must be compatible with your words.

7. Facial expression

   a. Exaggerate your facial expressions.

   b. Your facial expressions must be compatible with your words.

   c. Remember to smile; serious expressions and frowning convey negative feelings to the resident.

   d. Use face to face communication so the resident can see your expressions and body language.

V. Summary and Conclusion

   A. Barriers to communication with AD residents

   B. Environmental considerations affecting communication

   C. Verbal communication

   D. Nonverbal communication

Effective communication skills can be learned. How well we communicate affects every day of our lives and every relationship we have. The effort put into learning to communicate effectively with AD residents pays off each time you have contact with a resident. It will result in a better experience for the resident and you.

LESSON PLAN: 2

COURSE TITLE: CONFUSED RESIDENT CARE

UNIT II : COMMUNICATION

INTERACTION ITEMS:

1. What barriers have you encountered when trying to communicate with AD residents? Which barriers could be attributed to an organic cause? Which barriers were caused by lack of communication skills? Which barriers could be linked to environmental factors?

2. Why are vocal qualities an important factor in verbal communication?

3. What is meant by style of communication?

4. What do you think are important factors when communicating nonverbally with the AD resident?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Have students form small discussion groups and talk about the feelings and attitudes they experience when caring for AD residents. Have a recorder list the feelings or attitudes that seem to be common to the group. Some of the responses that may surface could be:

   a. Frustration - they do not understand what residents want from them.
   b. Anger - residents do not do what they are told.
   c. Agitation - it takes so long to care for AD residents.
   d. Guilt - they want to help residents but they get angry with them instead.
   e. Resentment - they may have just made a resident's bed and then return to find it unmade with the resident gathering the sheets for the laundry.

   Reassemble as a large group and talk about each group's list as it relates to the attitude cycle. Emphasize that their attitude affects their verbal and nonverbal communication and in turn affects the result of the interaction with the resident. With an improved understanding of the Alzheimer resident's behavior, the caregiver can, in many cases, alter his/her perception and thus change the end result.

2. Use Handout 5 to role-play two situations involving communication with an AD resident.

LESSON PLAN: 2

COURSE TITLE: CONFUSED RESIDENT CARE

UNIT II : COMMUNICATION

EVALUATION ITEMS:

1. List two barriers to communicating with Alzheimer's disease residents.

   a.

   b.

2. List two environmental considerations which could enhance communication with the AD resident.

   a.

   b.

3. List four ways verbal communication should be modified when communicating with a confused resident.

   a.

   b.

   c.

   d.

3. List four ways nonverbal communication should be modified when communicating with a confused resident.

   a.

   b.

   c.

   d.

LESSON PLAN: 2

COURSE TITLE: CONFUSED RESIDENT CARE

UNIT II : COMMUNICATION

ANSWERS TO EVALUATION ITEMS:

1. a. Brain damage - causes intellectual impairment and loss of comprehension and affects ability to form cohesive thought patterns
   b. Memory loss - resident cannot remember what happened seconds before (short-term memory loss); cannot remember what he/she wanted to say
2. The student may list any two of the following:
   a. Before communicating, reduce environmental stimuli by eliminating distracting background noises.
   b. Before communicating be sure the AD resident who has a hearing aid and/or glasses is wearing them.
   c. Never use the intercom system to communicate with an AD resident or to communicate with others when you are in the presence of the AD resident.
   d. Communication may be enhanced in rooms that are bright and cheerful.
3. The student may list any four of the following:
   a. Vocal qualities - Do not whisper; do not shout; speak slowly and at a low pitch; modulate your voice so that it is quiet and calm
   b. When asking questions - ask questions that are short and simple; keep questions direct and to the point; ask just one question at a time; repeat a question exactly as asked the first time
   c. When making brief comments - repeat a question or command exactly as stated the first time; give positive instructions, avoid saying "don't" or giving negative commands; always get a resident's attention by calling his/her name; as soon as eye contact is made begin speaking to the resident; make direct references to persons and objects, avoid the use of pronouns
   d. Use an appropriate style of communication - use phrases that show interest; as you speak, remember to also convey the intended message with body language; while speaking or gesturing, establish and maintain eye contact with the resident; use appropriate gestures that will reinforce what you are saying
   e. Paraphrasing - totally eliminate the tendency to restate sentences; repeat a request or statement word for word, exactly as stated the first time
   f. Remember to empathize - convey empathy primarily with body language; do not clutter a message with more words than needed to convey meaning

4. The student may list any four of the following:
    a. Eye behaviors - make eye contact before speaking; maintain eye contact throughout your interaction with the AD resident
    b. Gestures - exaggerate your gestures; be sure your gestures and body movements are compatible with your words; make sure your gestures are calm and gentle no matter what your personal feelings are; be consistent with the gestures you use with a specific resident, using the same gesture to express the same idea each time you communicate with him/her; demonstrate to the resident what you are trying to communicate to him/her
    c. Touching - touch the resident gently
    d. Posture - position yourself at the same level as resident; if you are at a higher level than the resident, he/she may feel threatened
    e. Physical distance - position yourself 1 to 1 1/2 feet from the resident initially
    f. Head behaviors - exaggerate the movements of your head; head movements must be compatible with your words
    g. Facial expression - exaggerate your facial expressions; facial expressions must be compatible with your words; remember to smile; serious expressions and frowning convey negative feelings to the resident; use face to face communication so the resident can see your expressions and body language

BARRIERS TO COMMUNICATING WITH AD RESIDENTS

Brain damage . . .

In the Alzheimer's resident, brain damage has caused intellectual impairment. Alzheimer's disease (AD) victims have difficulty interpreting information and expressing their thoughts. Alzheimer's disease victims have brain damage. They are not being uncooperative or stubborn just to make the caregiver's job difficult. AD victim's thoughts are not logical. The brain cannot put two thoughts together to form a cohesive thought pattern. For AD victims, life is like walking in on the middle of a conversation. They do not know what has happened before and, therefore, do not understand what is happening now.

Memory loss . . .

Short-term memory loss causes AD residents to lose the ability to remember what has occurred in the past few minutes. This adds to their overall intellectual impairment. Even though Alzheimer's residents appear normal, they are not able to communicate normally. Furthermore, because some routine conversations have become ingrained in residents' minds, they can successfully participate in superficial conversations. After 40 to 60 years of responding in the same manner to inquiries such as, "How are you?", the AD resident seems perfectly normal when he or she replies, "I am fine." Because of their normal appearance and simple responses, we expect AD residents to respond at higher levels, but, in fact, they cannot. This can be extremely frustrating to caregivers.

AD residents may also have difficulty with comprehension. Although he/she may be able to read, the AD resident's brain does not function properly, and cannot attach meaning to the words that are read. One would expect that if the resident can read, he/she can comprehend; but this may not be the case. Do not expect the AD resident to read a sign and understand what it means.

COMMUNICATING WITH AD RESIDENTS

Simplify verbal communication . . .

All AD victims are not necessarily hard of hearing, although that is a conclusion you might come to. Frequently, the AD resident's total lack of responsiveness to your attempts at verbal communication stem from an inability to understand what he/she hears. Speaking loudly or raising your voice will not improve communication (except in the case of the responsive resident who is hard of hearing). In fact, straining your voice to speak loudly could be mistaken for anger. This could upset the resident and make communication even more difficult. When talking to an AD resident, remember these points:

- Speak slowly, at a normal level, and in a low pitched voice
- Use short, familiar words and simple sentences
- Ask only one question or give one direction at a time
- Give positive instructions, avoiding "don't..." or negative commands
- Avoid questions or topics of conversation that require a lot of thought, memory, and words
- Avoid instructions that require the resident to remember more than one action at a time

Be aware of indications that the resident is not listening. This could include lack of direct eye contact, head or body turned away, and lack of typical responses such as nodding and facial expression. Touching the resident, holding his/her hand or placing your hand on the resident's shoulder may help improve listening and attention. Even if the resident appears to be listening, do not assume she/he understands everything you have said or that it will be remembered.

Wait for the resident to answer a question or respond to instructions before adding other questions or instructions. If the resident does not respond, ask the question or give the instructions again, using exactly the same words. To rephrase a question or statement will confuse the resident even further.

If the resident becomes uncooperative or refuses to act, do not force the issue, but try asking again a few minutes later. The resident may forget why she/he refused to respond the first time, and cooperate when you ask again.

When talking with other people and the resident is present, fully include the resident in the conversation. Do not assume that the resident does not understand what you are saying, particularly when you are talking about him/her to family, friends, doctors, etc. Avoid whispering and holding "quiet" conversations in the resident's presence. This may make the resident suspicious and could undermine your relationship with her/him.

Use nonverbal communication . . .

Communication is nonverbal as well as verbal. Body language, or how a person acts, is an important tool a caregiver can use to communicate with the resident. Observing the resident's body language can also be helpful in the communication process. Because the AD resident's body language is generally involuntary, it can be more telling and "truthful" than words.

AD residents often will pick up on your mood and respond more to the "climate" and tone of communication than to anything else. AD residents are often especially sensitive to your body language and tone of voice. An easygoing non-aggressive posture, calm voice and reassuring mannerisms all help to promote good communication experiences with the resident.

Nonverbal signals are actually a kind of informal sign language, which can be helpful in communicating with the resident. The resident may be able to see and imitate your movements more easily than she/he can process words and instructions. The resident's behavior modeling ability is usually quite proficient.

As you speak, also physically demonstrate what you would like the resident to do, from folding laundry to brushing teeth. To the resident, your actions may speak louder than your words.

You also can show praise and approval nonverbally. A caring smile, pat or hug show that you are paying attention, and builds communication and trust. However, be aware that during periods of suspicion or distrust, a resident may not appreciate, and may possibly react forcefully to resist physical contact.

Adapted from HOME CARE WITH THE ALZHEIMER PATIENT published by the Alzheimer's Disease and Related Disorder Association, Inc. pp. 8-10.

HO 3

VERBAL COMMUNICATION

MODIFICATIONS FOR ALZHEIMER'S RESIDENTS

Vocal Qualities	Do not whisper	This may make AD residents suspicious. If talking quietly, nearby residents will wonder what is being said about them.
	Do not shout	If resident cannot understand do not speak loudly unless resident is partially deaf and responds to increased volume.
	Speak slowly/low pitch	Low-pitched, slow speaking voice is what older adults hear best.
	Speak in a quiet calm voice	AD residents can perceive impatience, and this may cause them to become belligerent and angry.
Speaking	Use SIMPLE words	
	Speak in simple sentences	
	When asking questions keep them short and to the point	
	Give one command at a time	Say "Wash your face." When resident finishes, say "Dry your face." Do not say "Wash and dry your face."

Speaking (Cont.)	Do not use PRONOUNS	Use only nouns. Telling resident to pick "it" up is confusing. Instead, tell resident to pick up "the wash cloth."
	Repeat a question or a command exactly as stated the first time	AD residents think slowly. When sentences are changed or words are added it takes them longer to understand.
	Positive instruction	Give positive instruction, avoid "don't..." or negative commands.
	Always get a resident's attention by calling his/her name	The AD resident continues to respond to his/her name during much of the disease. As soon as eye contact is made, speak to resident, because attention may last only a few seconds.
Appropriate Style	When showing interest, use verbal phrases sparingly and body language liberally; emphasize eye contact	
	Nod head at appropriate times	
	Paraphrasing should be totally eliminated	Replace with direct simple questions or statement. When repeating a request or statement ALWAYS repeat word for word, exactly as stated the first time.

Appropriate Style (Cont.)	Empathizing should be expressed primarily through body language; direct eye contact or a gentle touch	Do not clutter the communication with more words than is needed to convey a simple message.

NONVERBAL COMMUNICATION

MODIFICATIONS FOR ALZHEIMER'S RESIDENTS

Eye Behaviors	Maintain eye contact	After calling a resident's name and getting his/her attention, look resident in the eye while speaking.
Gestures	Exaggerate gestures, body movements	Make sure gestures and body movements are compatible with words.
	Use a calm, gentle, and consistent approach no matter what personal feelings are	Always be aware of how easily strong emotions can be conveyed to residents. If the day is hectic and the AD resident is approached in a "RUSHED" manner, it will confuse and upset the resident.
Touching	Touch gently	Touch gets attention. It can convey caring and love. (Caution: some residents will respond to touch as if threatened. DO NOT take this response personally.)
Posture	Same level as the resident	Remember, interpretation is exaggerated.
Physical Distancing	One to one and a half feet initially	Same caution as touch
Head Behavior	Exaggerate	Be sure compatible with words

Facial Expressions	Exaggerate facial expressions	Be sure to use facial expressions that are compatible with words.
	Smile	A frown will convey negative feelings to the resident.
	Use face-to-face communication	Make sure residents can see facial expressions and body language.

ROLE PLAYING

Situation #1: Mrs. Jones is 70 years old. She has AD and is very confused. Mrs. Jones is living in your facility.

Role Player #1: AD resident - Mrs. Jones

It's 3 a.m. and a woman who you do not know is trying to get you to do something. You do not know what it is she wants you to do. If she would show you what to do, you would do it, but you cannot understand a word she is saying. It all sounds like Greek. All you can say is "but I don't want to fish."

Role Player #2: Caregiver

It's 8 a.m. and Mrs. Jones just finished breakfast. You want her to brush her teeth. She always has food stuck in her teeth and your supervisor is going to come back in five minutes to make sure you got her to brush her teeth. She's confused and you know you really need to work hard to get her to understand. Convince her to brush her teeth.

Situation #2: Mrs. James is 68 years old and lives in a nursing home. She has AD and wanders everywhere. Right now she is walking out the front door of the home, "for lunch" she says. It's actually 3 p.m. She insists that she really needs to hurry or she will be late. She is to "meet her sister at noon."

Role Player #1: AD Resident - Mrs. James

You must meet your sister at noon for lunch. You can only remember what the nursing assistant is telling you for about 30 seconds. Try to convince her that you need to leave but the only thing you can say is "I'm meeting my sister for lunch; I have to meet her at noon."

Role Player #2: Caregiver

You see Mrs. James heading for the front door and she is telling everyone "I'm meeting my sister for lunch. I have to meet her at noon." Her sister died three years ago. Besides, it is winter and she does not have her coat on and there is no one to go with her. Try to convince her not to go.

LESSON PLAN: 1

COURSE TITLE: CONFUSED RESIDENT CARE

UNIT III : SPECIAL CARE NEEDS

SCOPE OF UNIT:

This unit covers special care needs of the Alzheimer's resident in the areas of activities of daily living, basic self-care, and safety precautions. Emphasis is placed on modifying nursing care to meet the special needs of the AD resident, including using such methods as task breakdown and modeling activities when working with confused residents. Aspects of behavior, including memory change and common AD behaviors, are also discussed along with appropriate management techniques.

INFORMATION TOPIC: III-1 OR DEMONSTRATION:

ACTIVITIES OF DAILY LIVING
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Identify general nursing care that relates to the AD resident.
2. Identify special care techniques for the AD resident to maintain adequate intake and output levels.
3. Identify modifications in daily routines that will meet the hygiene needs of the AD resident.
4. Identify techniques used to meet the mobility needs of the AD resident.
5. Identify methods used to provide a safe environment for the AD resident.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

INFORMATIONAL ASSIGNMENT: (Student)

Nurse Assistant in a Long-Term Care Facility. Columbia, MO: Instructional Materials Laboratory, University of Missouri - Columbia, rev. 1987. Review Unit I, Lesson Plan 5, "Communication Skills."

Read this lesson prior to class and be prepared to discuss the information presented.

REFERENCES: (Instructor's Additional Information)

Allaire, Barbara and Robert McNeil. Teaching Patient Relations in Hospitals, the Hows and Whys. American Hospital Publishing, Inc., AHA, 1983, pp. 61-138. AHA catalog no. 049150.

Krewson, Jacalyn. Alzheimer's Disease: Teaching Series for Health Care Providers, Instructor's Manual. Pennsylvania Department of Aging, Units 3 and 4.

Greater New York Hospital Foundation, Inc. AIDS and Alzheimer's Disease. A Training Manual for Health-Care Teams about Coping with Chronic and Terminal Illnesses. 1988, pp. 54-56.

Nurse Assistant in a Long-Term Care Facility. Columbia, MO: Instructional Materials Laboratory, University of Missouri - Columbia, rev. 1987.

INTRODUCTION:

Providing care for a resident with Alzheimer's disease (the "AD" resident) requires sensitivity to and understanding of the multiple behavioral and physiological changes that are manifested as the illness takes its course. Because Alzheimer's residents typically become increasingly disoriented and unable to attend to their basic needs, the areas of care that require particular attention are nutrition, hygiene, safety, activity/rest, psychological manifestations of depression, agitation, and confusion.

LESSON PLAN: 1

COURSE TITLE: CONFUSED RESIDENT CARE

UNIT III : SPECIAL CARE NEEDS

OUTLINE: (Key Points)

NOTE: If students do not have copies of this manual, it would be helpful to photocopy this information outline and distribute to students as a note-taking aid.

I. Nursing Care for the Alzheimer's Resident

   A. General principles of nursing care apply for all residents.

      1. Encourage resident to be as independent as possible to help maintain his/her self-esteem

      2. Give positive reinforcement to residents whether residents are independent or dependent

   B. Deterioration is part of the AD process. No matter how good the quality of care is, resident's abilities (following directions, making sound judgments, etc.) will deteriorate.

   C. Benefits of specific nursing care measures for AD residents delivered by capable caregivers

      1. Enhances resident's comfort and quality of life

      2. Assures the safety of the resident

      3. Reduces daily stress for the resident, his/her family, and staff

      4. Establishes a relationship between caregiver and resident which heightens resident's trust level

   D. Specific nursing measures for AD residents

      1. Concentrate on what AD resident can do, not what he/she cannot do.

      2. Caregivers must strive to change their own behaviors and responses, not those of the residents; anticipate problems and plan how to avoid them.

3. Talk to the AD resident in an adult-like manner.

4. The use of a very structured routine is extremely important; it assists with orientation of residents.

5. If at all possible, organize other work around AD residents.

6. When the resident is "HABIT TRAINED," they more easily accept care and anxiety is lessened.

7. Soothing music is excellent to include with care. This has a positive and sometimes startling effect.

II. Intake and Output

A. Nutritional problems - AD residents have particular problem in this areas

1. Memory impairment - the AD resident forgets to eat or eats too often

a. Excessive eating and vomiting can reach bulimic proportions

b. Severe electrolyte imbalance can occur

c. Residents may forget that they just ate and want more food; weight gain can become a problem

d. Food is more than just nourishment; resident may retain memories associated with food

(1) Caring

(2) Nurturing

(3) Social interaction

(4) Pleasure\gratification

2. In the later stages of the disease, residents forget how to eat and may eventually forget how to swallow

a. Mouthing without swallowing is common; resident may need to be reminded to chew

b. Playing with food is also common

        c. Increased risk of aspiration because resident forgets to swallow

    3. Psychomotor ability decreases

        a. Assistance with cutting food and taking fluids may be needed

        b. Residents eventually start to use their fingers when eating; even soup and water

        c. Decreased coordination contributes to awkwardness and messy eating habits; the brain and hand do not work together

    4. Residents' particular likes and dislikes are marked; special cravings may be apparent for days and weeks, to the extent that the resident refuses to eat anything else

    5. Residents cannot be reasoned with to encourage proper nutrition

    6. Residents cannot tell what is edible, and what is not; may try to eat flowers, napkins, plastic fruit, etc.

    7. CAUTION: Fluids are often withheld in an attempt to decrease periods of incontinence, with the end result being dehydration.

B. Specific nursing care for the resident with nutritional problems

    1. Make sure the environment is calm and quiet; soft background music can be helpful. This may enable the resident to concentrate on her/his food.

    2. Use plastic glasses and bowls which are lighter and therefore easier for the resident to manage. Plastic is also safer, eliminating the possibility of broken glass.

    3. Use heavy silverware, especially spoons, to act as a tactile reminder to the resident that he or she is eating.

    4. As resident's eating skills diminish, use:

        a. Bowls instead of plates

        b. Cups for soup

        c. Only the utensil needed to eat a particular type of food; offering unnecessary utensils will confuse the resident.

    5. Use bright colors on the table to stimulate appetite.

    6. Keep a damp washcloth under dishes to keep them from sliding.

    7. Offer only one food at a time. This will reduce the need for the resident to make a choice, which at mealtime, often results in the resident playing with her/his food.

    8. Season food for the resident then remove the condiments, as he/she may forget it was already seasoned and insist that it be done again.

    9. Keep a dish of low-calorie finger foods available for times when the resident feels hungry or forgets having just been feed; also promotes good nutrition and allows resident to be self-sufficient.

    10. Always remind the resident to swallow.

    11. Check the temperature of foods to avoid burning.

    12. Cut resident's food into small pieces so if resident forgets to chew the food the possibility of choking will be reduced.

    13. To avoid dehydration and limit the possibility of incontinence, encourage fluids during the daytime hours; restrict fluids a few hours before bedtime.

III. Hygiene

A. Bathing problems

1. Residents are often afraid of bathing.

2. A change or radical departure from a former routine can be very difficult and upsetting to confused persons.

3. Bathing involves many decisions such as getting undressed, washing, then choosing what put on; resident knows he/she cannot do all of these things, so he/she may not want to do any of them.

4. Undressing in front of others, and having others touch and wash their aging bodies is embarrassing for some residents. (II-1)

5. If resident is too confused to understand what the caregiver is doing when assisting with bathing or dressing/undressing, the resident may think the caregiver is trying to assault him/her.

6. Loss of the sense of time may cause residents to think they took a bath yesterday, when actually, it was a week ago. Remember also, for many older people their routine was to bathe only once a week (not every day).

B. Specific nursing care for the resident with bathing problems

1. Identify the resident's usual hygiene routines. (II-2)

    a. Establish a bathing routine in accordance with the resident's preferences as much as possible.

        (1) Time of day

        (2) Type of bath products (soap) preferred (II-3)

        (3) Bath versus shower

    b. If resident refuses a tub bath, offer a shower.

2. If resident becomes angry

    a. Leave the resident and come back later; memory loss can work to the caregiver's advantage as the resident will probably not remember the previous attempt and may freely cooperate on the second try.

    b. Do not get angry; stay calm and avoid power struggles.

    c. Encourage the resident to focus on the pleasurable sensation of the bath.

    d. Try a different caregiver; sometimes the resident will cooperate with one person and not another.

3. Determine the degree of assistance the resident requires to meet self-care needs.
    a. Check water temperature to avoid burns.
    b. Encourage the resident to participate by reminding her/him to wash and always reinforce positive hygiene behavior.
    c. Remind the resident of the steps in dressing or undressing, taking care to give just one instruction at a time.
    d. Use clothing with simple closures and elastic bands to promote the resident's self-care.
    e. Break a complex task down into smaller tasks (steps).
4. Do not give residents time to think about what they are about to do. Have the water ready and say, "Your bath is ready."
5. If the resident says, "I don't want to take a bath," ignore it; slowly repeat the directions and go on to the next step. This may divert the resident's attention.
6. Establish a regular routine. Do everything in exactly the same way. In time, the routine will become habit.
7. Check the temperature of bath water, even if the resident already has. The AD resident's perception of temperature may be inaccurate.
8. Remember that residents may not need a full bath daily.
9. AD residents have the ability to imitate. Caregivers should take advantage of this and model desired behaviors such as washing his/her arms with a (dry) washcloth while the resident watches. This may encourage the resident to try the same on his/her own.
10. If the resident is afraid of bathing, place only two or three inches of water in the tub to make the resident feel more secure.

C. Toileting problems - toileting can be a very difficult part of providing care, but it is probably the easiest to improve.

  1. The resident may void wherever she/he happens to be.
  2. The resident may not remember where the bathroom is located.
  3. The resident may not understand that discomfort may be due to the fact that he/she has to go to the bathroom.
  4. If the resident does awaken at night to go to the bathroom she/he may be too confused or frightened to find the bathroom.
  5. Resident may tell you he/she does not have to go to the bathroom and then be incontinent seconds later.

D. Specific nursing care for the resident with toileting problems

  1. When residents are wandering, they are often searching for the bathroom.
  2. Most AD residents should be taken to the bathroom every two hours while they are awake.
  3. If the resident awakens during the night, he/she will want to go to the bathroom.
     a. A night light will help guide the resident to the bathroom and lessen confusion.
     b. Keep resident's room free of clutter to prevent injury when going to the bathroom.
  4. Resident should be taken to the bathroom upon awakening in the morning; have slippers available for resident as he/she may be stimulated to void immediately when bare feet contact cold floor.
  5. If resident says he/she does not need to use the bathroom:
     a. Instruct/assist resident to pull down underwear and be seated on the toilet; this usually triggers the urge to void.

    b. If resident still cannot void, the sound of running water in the bathroom sink may initiate the urge to void.

6. The task of removing clothing to go to the bathroom may be too difficult for some residents.

    a. Females are able to help themselves more if they wear slacks with elastic waistbands.

    b. Males may have a Velcro® closing instead of a button and zipper fly.

7. A picture of a commode on the bathroom door may help the resident remember where bathroom is.

8. Have resident avoid fluids after 9 p.m. (or earlier to allow several hours prior to bedtime) to prevent waking at night to use the bathroom.

9. Praise residents for everything they do correctly. Ignore aspects that were done incorrectly.

E. Dressing and grooming - a resident's biggest problem with getting dressed is the number of decisions that must be made

F. Specific nursing care for the resident with dressing and grooming problems

1. Encourage residents to dress in street clothes. Wearing pajamas or robes in the daytime makes them feel sick and unmotivated.

2. To help residents, caregivers should limit choices according to what each resident can handle.

    a. "Do you want to wear the yellow dress or the blue one?"

    b. Eventually, the caregiver may need to tell the resident, "This is what you'll wear today," in a nondemanding tone.

    c. Simple patterns and pastels are usually best.

3. Lay out all clothing the resident will need. Arrange in the correct order in which it is to be put on.

    a. Clothes should be turned right side out, as residents will not remember to do this.

b. The caregiver may need to hand the resident the clothing, one piece at a time, and tell the resident step-by-step how to put each item on.

c. It may be easier for the caregiver to dress the resident, but the resident should be allowed to do as much as he/she can to promote feelings of self-worth.

4. Hair is most easily managed when it is kept short but attractive.

5. If female residents are willing to go to the beauty shop, it is beneficial not only to the resident, but the staff as well; this extra attention and primping adds to the resident's self-esteem.

6. Pay special attention to dental care.

a. Encourage residents to do as much as they can.

b. Caregiver should assist only as needed.

c. Once again, utilize resident's imitative ability by modeling how to brush your teeth.

IV. Mobility

A. Complications from immobility often lead to death with AD residents. They should be given as much exercise as possible.

B. Activity (II-4)

1. Include daily exercise, outdoors if possible.

2. Develop a daily routine for the resident.

3. A change in routine can be very difficult and upsetting to the confused person.

4. Develop schedules that alternate periods of activity and rest.

5. Guard against resident exhaustion.

6. Involve the resident in a safe activity to channel restlessness.

7. Support regular day/night routines that are not forced.

8. Include activities a few hours before bedtime to help the resident sleep and decrease incidents of wandering.

9. Do not keep the AD resident in bed. This causes sensory deprivation and increases confusion.

B. Rest

1. Identify resident's usual pattern of activity/rest cycle.

2. Determine limitations and alterations in activity/rest patterns as a result of the disease.

3. Identify resident's previous patterns of work, leisure, and rest before onset of AD. This information can be obtained from the resident's family.

4. To facilitate rest and sleep, utilize comfort measures.

    a. Evening care

    b. Back rubs

    c. Decrease stimulation

5. Carefully evaluate evening showers. Use only if this relaxes the resident. Most often it stimulates.

6. Insomnia/sleep disturbances

    a. Encourage short afternoon naps.

    b. Try to encourage a later bedtime if the resident tends to be an early riser.

    c. If resident is a late riser, avoid naps and late bedtimes.

7. Dim lights kept on in bedroom at night help residents organize their thoughts and may help them not to be frightened if awakened. Darkness adds to residents' confusion.

V. Safety - a safe environment is critically important to the AD resident because of the tendency to wander and the problem of cognitive dysfunctioning.

A. AD resident should wear an ID band with name, phone, and statement of memory impairment.

B. Surround resident with familiar objects when he/she enters a new setting; keeps the resident from hunting for his/her old room.

C. Place bells and/or alarms on all exits.

D. Supervise the resident in simple, daily exercises such as taking walks or dancing.

E. Floors should have a dull finish to help prevent confusion and falls.

F. All large rooms should be labeled with names, pictures, or special colors on door to assist resident in locating and recognizing the room.

G. Avoid using restraints if at all possible. Restraints usually make residents more agitated. Weigh benefits of safety.

VI. Summary and Conclusion

A. Nursing care for the Alzheimer's resident

B. Intake and output

C. Hygiene

D. Mobility

E. Safety

Working with AD residents can be viewed as hard work or as a challenge. AD residents may be seen either as difficult and demanding burdens, or as people in need of love. It is important for caregivers to understand that the time AD residents are most unlovable are the times they need love the most. It takes a staff with very caring attitudes to work with AD residents. The reward comes when the caregiver sees the spark of happiness in the resident's eyes or when the resident reaches out to touch the caregiver's hand because she or he took the time to care. The caregiver can be the sunshine in the confused world of AD victims.

By slowing down, organizing the day, and communicating with coworkers, the CNA can provide a caring and more calming environment for AD residents.

LESSON PLAN: 1

COURSE TITLE: CONFUSED RESIDENT CARE

UNIT III: SPECIAL CARE NEEDS

INTERACTION ITEMS:

1. How would you feel if you had to undress in front of strangers?
2. How many of you bathe at night, how many in the morning?
3. Do you have favorite products to use at bath time?
4. What would you see if you were in bed all the time in a semi-Fowler or side-lying position?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

LESSON PLAN: 1

COURSE TITLE: CONFUSED RESIDENT CARE

UNIT III : SPECIAL CARE NEEDS

EVALUATION ITEMS:

For each of the following, write "T" if the statement is true, or "F" if it is false.

____ 1. A resident who cannot get the toothpaste on the toothbrush should not be allowed to brush her/his teeth.

____ 2. Tell AD resident, Mrs. Smith, that she did a good job of sitting on the toilet and going to the bathroom even though she forgot to pull her underwear down.

____ 3. The AD resident's ability to follow directions and make judgments deteriorates regardless of what is done, so practicing special care techniques is a waste of the caregiver's time.

____ 4. Deterioration is part of the disease process, no matter how good the quality of care is.

____ 5. Caregivers can make the residents' lives better and more comfortable with good care.

____ 6. Concentrate on what AD residents can do, not what they cannot do.

____ 7. Fluids are often withheld in an attempt to control incontinence, with the end result being dehydration.

____ 8. Residents must change their behavior and responses, and the caregiver does not.

____ 9. Talk to the AD resident in an adult-like manner.

____ 10. A structured routine is NOT important for the AD resident.

____ 11. Establishing a relationship between caregiver and resident heightens the resident's trust level.

____ 12. Music has a positive effect on residents.

For each of the following, circle the letter of the correct answer.

13. Due to memory impairment the AD resident forgets to eat or eats too often; this can result in:

a. Vomiting
b. Severe electrolyte imbalance
c. Weight gain
d. All of the above

14. Psychomotor skills decrease, therefore the resident may need assistance with:

a. Cutting food
b. Drinking fluids
c. Getting food from dish to mouth
d. All of the above

15. In the later stages of Alzheimer's disease, residents forget how to eat. Which of the following are possible problems or complications?

a. Mouthing food without swallowing
b. Playing with food
c. Aspiration
d. All of the above

For each of the following, write "T" if the statement is true, or "F" if it is false.

____ 16. Using heavy silverware, especially spoons, acts as a tactile reminder to the resident that they are eating.

____ 17. To avoid dehydration and limit problems with incontinence, encourage fluids during the daytime hours. Restrict fluids a few hours before bedtime.

____ 18. Residents are often afraid of bathing.

____ 19. Undressing in front of others, and having others touch and wash his/her aging body is never a problem of embarrassment for most residents.

____ 20. If residents are too confused to understand what the caregiver is doing, they may think the caregiver is going to hurt them.

____ 21. Identifying what the resident's normal bathing routine is will make the process more familiar to the resident and less frightening.

____ 22. Clothing with simple closures and elastic bands makes it easier for the AD resident to manage, and allows her/him to continue some independence in self-care.

____ 23. Breaking tasks down into smaller tasks and waiting for the resident to complete each step of the process promotes successful completion of tasks by the resident.

____ 24. Establishing a regular routine and doing everything in exactly the same way establishes a routine which will become a habit. This is of no benefit to the resident but is done to utilize the caregivers's time more effectively.

____ 25. AD residents have the ability to imitate. This can be utilized by the caregiver when modeling self-care practices to the resident.

____ 26. If the resident is afraid of bathing, place only two or three inches of water in the tub to make the resident feel more secure.

____ 27. AD residents do not understand that their discomfort is because they have to go to the bathroom.

____ 28. If the resident does awaken at night to go to the bathroom they may be too confused or frightened to find the bathroom.

____ 29. When residents wander, often they are looking for the bathroom.

____ 30. All AD residents should be taken to the bathroom every two hours while they are awake.

____ 31. A picture of a commode on the bathroom door will probably not be of value in helping the resident to remember where the bathroom is located.

____ 32. The AD resident should not consume fluids after 9 p.m. to prevent waking at night to use the bathroom.

____ 33. A resident's biggest problem with getting dressed is the number of decisions that must be made.

____ 34. Encourage the resident to dress in street clothes, as wearing pajamas during the day makes one feel sick and unmotivated.

____ 35. Complications from immobility often lead to death with AD residents,so they should exercise as much as possible.

____ 36. Keeping the AD resident in bed causes sensory deprivation and increases confusion.

For each of the following, circle the letter of the correct answer.

37. A daily exercise/activity for the AD resident should include:

a. Outdoor exercise, if possible
b. Schedules that alternate periods of activity and rest
c. Involve the resident in a safe activity to channel restlessness
d. All of the above

38. When trying to identify activity needs for each AD resident, the following should be assessed:

a. Resident's usual pattern of activity/rest cycle
b. Limitations and alterations in activity/rest pattern as result of the disease
c. Identify what the resident's patterns of work, leisure, and rest were before the onset of illness
d. All of the above

For each of the following, write "T" if the statement is true, or "F" if it is false.

____ 39. A safe environment is critically important to the AD resident because of the tendency to wander and the problem of cognitive dysfunctioning.

____ 40. All AD residents should wear an ID band with name, phone, and statement of memory impairment in case they get lost.

____ 41. Avoid restraints if at all possible. Restraints usually make residents more agitated.

LESSON PLAN: 1

COURSE TITLE: CONFUSED RESIDENT CARE

UNIT III : SPECIAL CARE NEEDS

ANSWERS TO EVALUATION ITEMS:

1. F
2. T
3. F
4. T
5. T
6. T
7. T
8. F
9. T
10. F
11. T
12. T
13. d
14. d
15. d
16. T
17. T
18. T
19. F
20. T
21. T
22. T
23. T
24. F
25. T
26. T
27. T
28. T
29. T
30. T
31. F
32. T
33. T
34. T
35. T
36. T
37. d
38. d
39. T
40. T
41. T

LESSON PLAN: 2

COURSE TITLE: CONFUSED RESIDENT CARE

UNIT III : SPECIAL CARE NEEDS

SCOPE OF UNIT:

This unit covers special care needs of the Alzheimer's resident in the areas of activities of daily living, basic self-care, and safety precautions. Emphasis is placed on modifying nursing care to meet the special needs of the AD resident, including using such methods as task breakdown and modeling activities when working with confused residents. Aspects of behavior, including memory change and common AD behaviors, are also discussed along with appropriate management techniques.

INFORMATION TOPIC: III-2 OR DEMONSTRATION:

BEHAVIOR PROBLEMS
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Identify changes in the AD resident that contribute to behavior problems.
2. Identify the most common types of behavior problems in the AD resident.
3. Identify techniques for managing the AD resident's problem behaviors.
4. Identify types of restraints often prescribed for the AD resident.
5. Identify complications associated with use of restraints on the AD resident.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

INFORMATIONAL ASSIGNMENT: (Student)

Nurse Assistant in a Long-Term Care Facility. Columbia, MO: Instructional Materials Laboratory, University of Missouri - Columbia, rev. 1987. Review Unit I, Lesson Plan 5, "Communication Skills."

Read this lesson prior to class and be prepared to discuss the information presented.

REFERENCES: (Instructor's Additional Information)

Allaire, Barbara and McNeil, Robert. Teaching Patient Relations in Hospitals, the Hows and Whys. American Hospital Publishing, Inc., AHA, 1983, pp. 61-138. AHA catalog no. 049150.

Krewson, Jacalyn. Alzheimer's Disease: Teaching Series for Health Care Providers, Instructor's Manual. Pennsylvania Department of Aging, Unit 2.

Greater New York Hospital Foundation, Inc. Aids and Alzheimer's Disease. A Training Manual for Health-Care Teams about Coping with Chronic and Terminal Illnesses. 1988, (212) 246-7100, p. 44.

Nurse Assistant in a Long-Term Care Facility. Columbia, MO: Instructional Materials Laboratory, University of Missouri - Columbia, rev. 1987.

New Jersey Department of Health, Managing the Client and Dementia: A Resource and Training Guide for Nursing Homes and Adult Day Care Centers. 1988, pp. 95-108.

ADRDA - St. Louis, MO Chapter. Home Care with the Alzheimer Resident 1988, pp. 18-25.

INTRODUCTION:

All behavior has a purpose - to satisfy one's needs. Behavior tends to be repetitive; people form habits. Some behaviors are reassuring to AD resident, and it is difficult to break these habits. With this in mind, behaviors of AD residents can be examined and interpreted. However, it is not always possible to understand what the AD resident wants by observing his/her behaviors.

89

LESSON PLAN: 2

COURSE TITLE: CONFUSED RESIDENT CARE

UNIT III: SPECIAL CARE NEEDS

OUTLINE: (Key Points)

NOTE: Types of brain damage and effects on behavior are addressed in Unit I.

I. Changes in the AD Resident that Contribute to Problem Behaviors

A. Lack of inhibitions - residents will do things they would never have done before; they do what they feel like doing, and say what they think (Example: May undress in public)

B. Lack of impulse control - must satisfy their needs immediately; if they want to go outside, they want to do it now, and cannot understand or tolerate a delay

C. Lack of frustration control - low tolerance for anything that prevents the immediate gratification of a basic need (Example: Resident may cry out because he/she is cold and unable to find a sweater)

II. Types of Behavior Problems Common in AD Residents

A. Sundowning - phenomena which occurs when behavior problems become worse in evening

B. Wandering - aimless walking which may result in a resident becoming lost

C. Pacing - walking repeatedly in the same place with no apparent direction in mind

D. Combative - belligerent behavior; can be verbal or physical

E. Rummaging - resident is intent on searching for something; because AD increases suspiciousness, resident may persist in hiding valued items and then search for them

F. Agitation - restless, nervousness; this may be early sign of a catastrophic reaction if the feeling of agitation is not relieved

G. Catastrophic reaction - overreaction to circumstances

H. Hallucination - sensory perceptions that seem real to the person experiencing them but are not perceived by others (seeing, hearing, feeling)

I. Delusions - incorrect beliefs that remain fixed in spite of all rational evidence to the contrary, for instance, the older female resident who thinks she is pregnant

III. Management of Difficult Behavior (II-1)

NOTE: Relate the following points to the information presented in Unit II on communication. Continue to reinforce the connection between communication and the AD resident's behavior. Several tips for managing behavior problems will be repeated in several sections due to the overlapping of the problems and solutions.

A. Memory loss - memory will to continue to deteriorate but there are some environmental changes that can maximize the existing memory capabilities

1. Keep frequently used personal belongings in the same place all the time (slippers, toothbrush). This encourages remembering, and allows residents to care more for themselves since the location of the item becomes ingrained.

2. Keep old pictures of residents, and their loved ones, in their rooms. This stimulates memory and provides the resident with something to talk about with others.

3. Keep brightly colored afghans on residents' beds at all times in order to help residents identify their own beds. When they see their afghans they will be cued to think "that's mine." Something similar could be used, but it should be bright.

4. Keep structure in the resident's day: serve breakfast at the same time each day, bathe resident at the same time, etc. Patterns become ingrained, and routines lessen anxiety.

5. Always identify yourself when you approach residents, even if it is many times a day. AD residents easily forget who caregivers are, and the introduction helps them to identify the caregiver as a friend.

B. Increased restlessness, nervousness, pacing, agitation

1. Always approach resident in a calm manner, no matter how difficult the circumstances. The resident experiences emotional responses even though he/she might not know why

2. Remove distracting stimuli, i.e., excessive noise, light, and movement.

3. Try to determine if resident's basic needs have been met. He/she may need to go to the bathroom or may be hungry. Eliminate the unmet need and the resident may calm down.

4. Plan exercise for residents. Allow them to pace in a safe and calm area or take them for a walk.

5. Try to passively break repetitive activities. If a resident is pacing in a circle, interrupt the route by placing a piece of furniture in the way. Do not be abrupt and confrontational.

6. Assure residents that you will take care of them. Residents are frequently confused and afraid, and they simply need to know they are secure and okay.

7. Offer only decaffeinated beverages to the resident. Caffeine increases restlessness.

C. Wandering

1. Allow resident to wander in a safe place. Wander can be a form of exercise.

2. Avoid crowded areas, excessive noise and activity, which will increase the resident's confusion and encourage escape.

3. Remember to take the resident to the bathroom. This is frequently what the resident is seeking.

4. Hang old, familiar pictures or other decorations on residents' doors to help them locate their own rooms.

5. Keep items that suggest outdoor activities and travel (overcoats, hats, etc.) stored in a closet or elsewhere out of sight. This may decrease the need to wander.

D. Loss of ability to follow directions, make decisions

1. Give only one command at a time.
2. Use short sentences.
3. Make sure you have a resident's attention by calling his/her name, and making eye contact before giving a command.
4. Offer only two choices.
5. Avoid arguing. If tension mounts, leave the resident and return a bit later.

E. Sundowning (insomnia/sleep disturbances)

1. Encourage short afternoon naps and late bed times if residents are early risers. If residents are late risers, avoid naps and late bedtimes. Too much sleep during the day causes inability to sleep at night. This frequently causes them to confuse day and night because their "internal clock" is confused.
2. Have consistent and simplified bedtime routines. Avoid evening stimulation like baths/showers. (However, there may be some residents who are relaxed by a warm bath.)
3. Provide continuous activity during the day, particularly walking, to prevent resident from sitting and dozing. Activity is important to tire residents out so they will sleep well through the night.
4. Keep a dim light on in residents' bedrooms, to help them organize their thoughts and prevent fright if awakened at night. Darkness adds to residents' confusion.
5. Give residents back rubs before bedtime to encourage relaxation.

F. Rummaging, suspiciousness, losing/hiding things

1. It is common for AD residents to accuse others of stealing. Remain calm and do not take this personally.
2. Offer to help residents find lost items; do not argue about the loss.

3. Carefully distract residents.

4. Learn residents' hiding places. They frequently use the same ones, and forget afterwards where they put things.

5. Label all residents' belongings. If they are in the wrong place, someone else will find them. Even label dentures (check with supervisor before doing this), because AD residents will wear anyone's and not realize they do not fit.

6. Provide a box or drawer that contains items to be fiddled with. This allows for safe rummaging and may satisfy the resident.

7. Closely supervise activities involving small objects that could be swallowed.

8. Ask if the resident needs to use the bathroom.

9. Offer calm reassurance that everything is in order and divert the resident to another activity.

G. Catastrophic reactions - When a situation overloads the AD resident's mental coping abilities, the resident may revert to impulsive, childlike and immature behavior. Any situation that may be mildly stressful for most people can grow way out of proportion for the AD resident.

1. AD residents can sense anger or frustration and they will respond accordingly. Therefore the caregiver must remain calm no matter how difficult it is.

2. It is important that resident's repetitive cycles be broken subtly; if this is not done, a catastrophic reaction can be triggered.

3. Do not respond to the resident's repetitive or angry words, but reassure residents that everything is okay.

4. If the resident's behavior or words are causing distress for other residents GENTLY distract the AD resident or separate the resident.

5. Sometimes, if a simple task or basic need cannot be met by the resident, they may scream out in frustration.

6. If the AD resident is having trouble understanding a directive, he/she may respond with catastrophic reaction. Remember the steps for giving directions.

(II-2)

7. When a certain activity always precipitates a catastrophic reaction, change that activity.

8. Do not attempt to force a resident's participation in anything.

9. Avoid situations where there are a lot of strangers, crowds, and small, cramped quarters.

10. Avoid activities that produce a lot of clutter, and activities or events where there is a lot of confusion and noise.

11. Sometimes catastrophic reactions cannot be avoided. If the resident does have a catastrophic reaction:

    a. Stay calm.

    b. Move slowly and announce your moves in advance.

    c. Sometimes rocking, patting, or holding will soothe the resident.

    d. Do not use any physical contact that may seem like restraint to the resident.

    e. As the resident calms down, go on to something else and do not replay the incident. Allow the resident's forgetfulness to erase the event.

H. Hallucinations/delusions (II-3)

1. AD blocks rational, ordered thinking and the ability to reach logical conclusions based on fact. Generally, delusions and hallucinations cannot be prevented in AD residents; but, these symptoms can often be successfully managed.

2. If the resident is upset by the delusion or hallucination, acknowledge his/her feeling of fear and provide reassurance that you are there to make things right. Try GENTLE, affectionate talk and contact for comfort. If the resident is agitated, be careful that physical contact is not mistaken for an attempt to restrain the resident.

3. Distraction - attempt to direct the resident into activities that will redirect the resident's attention.

4. No amount of reasoning, explanation, or proof to the contrary will convince an AD resident that the things she/he believes or feels are not real.

IV. Use of Restraints

A. Restraint - any device which places external control on the resident's behavior

NOTE: The use of restraints on residents is currently a controversial issue. Chemical and physical restraints should be used only when all other measures to keep the resident safe have failed. The decision to restrain a resident should be made after careful assessment by the resident's physician, and only after an order from the physician is obtained.

B. Types of restraints

1. Chemical

a. Sedatives

b. Tranquilizers

c. Hypnotics

d. Other medications used to control the resident's behavior

2. Physical

a. Soft restraints - wrist, ankle, waist, or chest (posey) restraints

b. Geri chairs

c. Sheets

d. Anything used to physically control the resident's behavior

C. Restraints usually make AD residents more agitated.

D. Restraints may provide temporary protection of the residents, but they will not eliminate the cause of the problem behavior and may worsen the disorientation and agitation.

E. Restraints do virtually nothing to enhance the cooperation of the resident.

F. Restraints do not foster the development of trust.

G. Restraints do not make use of the resident's remaining capacities.

H. Application of restrains does not facilitate a search for the meaning behind the behavior.

I. Restraints provide only a temporary "solution" to the problem behavior; they must not be relied upon as the major means of intervention.

J. Chemical restraints can cause increased problems.

    1. Increase in hallucinations

    2. Increase in combative and agitation

    3. Increase in elimination problems (urine and bowel movements)

    4. Improper nutrition may result from resident's loss of appetite or he/she may be too sedated to eat or drink.

V. Summary and Conclusion

A. Changes in the AD resident that contribute to problem behaviors

B. Types of behavior problems common in AD residents

C. Management of the difficult behavior

D. Use of restraints

What works with one resident may not work with another. What worked today with a particular resident may not work with that same resident again tomorrow. Knowing and using a variety of approaches will improve your skills as caregiver. Always try to remember that AD residents cannot modify their behavior. If the world seems bizarre to you, it is even more bizarre from the residents' perspective, and that's why their behavior is unpredictable.

LESSON PLAN: 2

COURSE TITLE: CONFUSED RESIDENT CARE

UNIT III : SPECIAL CARE NEEDS

INTERACTION ITEMS:

1. What types of behavior problems have you seen while caring for the AD resident?
2. What are the steps for giving the AD resident commands?
3. What types of hallucination/delusions have you seen the AD resident demonstrate?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

LESSON PLAN: 2

COURSE TITLE: CONFUSED RESIDENT CARE

UNIT III: SPECIAL CARE NEEDS

EVALUATION ITEMS:

For each of the following, circle the letter of the correct answer.

1. Mrs. Jones is an AD resident who keeps taking off her clothes in front of the other residents. This problem behavior can be attributed to lack of:

   a. Inhibitions
   b. Frustration control
   c. Manners
   d. Impulse control

2. Mr. Johnson is an AD resident who is cold, but cannot find his sweater. Mr. Johnson just stands up and screams and cries. This problem behavior can be attributed to lack of:

   a. Impulse control
   b. Inhibitions
   c. Frustration control
   d. Respect

3. You are going to take Mr. Smith for a walk. As you leave to go and get your coat, Mr. Smith becomes extremely angry with you. Mr. Smith wants to go on his walk right now and will not wait. This problem behavior can be attributed to lack of:

   a. Frustration control
   b. Manners
   c. Inhibitions
   d. Impulse control

For each of the following, match the description to the correct term.

____ 4. Resident appears to be searching for something.

____ 5. Resident becomes increasingly confused and difficult to handle after sunset.

____ 6. Resident aimlessly walks around and frequently becomes lost.

_____ 7. Resident physically resists being moved from the bed to the chair and becomes verbally abusive.

____ 8. Resident is frequently found walking back and forth in the same spot in his room.

____ 9. Resident has a frown on her face and is slapping her hand on the table top.

____ 10. Resident is seated at a table talking to others around the table, but you don't see or hear anyone else at the table.

____ 11. The caregiver removed an empty dinner plate from in front of the resident and she starts to scream and cry out of control.

____ 12. A elderly female resident insists that she is pregnant.

a. Sundowning

b. Wandering

c. Pacing

d. Combative

e. Rummaging

f. Agitation

g. Catastrophic reaction

h. Hallucination

i. Delusions

For each of the following, write "T" if the statement is true, or "F" if the statement is false.

____ 13. Memory loss in the typical AD resident will continue to get worse, but there are some environment changes that can maximize the existing memory capabilities.

____ 14. Keeping frequently used personal belonging in the same place all the time, encourages remembering, and allows residents to care more for themselves.

____ 15. Old pictures of residents, and their loved ones kept in the residents' rooms stimulates memory and offers something to talk about with others.

____ 16. Brightly colored afghans placed on residents' beds at all times helps them identify their own beds.

____ 17. Structure in the resident's day is for the convenience of the caregiver since there is no benefit to the AD resident.

____ 18. AD residents easily forget who caregivers are, so you should introduce yourself each time you have contact with the resident.

____ 19. Approach residents in a calm manner, no matter how difficult the circumstances.

____ 20. Excessive noise, light, and movement do not affect AD residents because they do not really understand what is happening around them.

____ 21. Many behavior abnormalities can be traced to a basic need of the resident which has not been met.

____ 22. AD residents do not require exercise. They are much too weak and confused to do any exercise at all.

____ 23. If a resident is pacing in a circle, interrupt his/her route by placing a piece of furniture in the way. (Do not be abrupt and confrontational.)

____ 24. Residents are frequently confused and afraid, and they simply need to know they are secure and okay.

____ 25. Caffeine does not increase restlessness.

____ 26. If wandering usually occurs at a specific time of day, restrain the resident to control the wandering.

____ 27. Keep items that suggest outdoor activities and travel (overcoats, hats, etc.) stored in a closet or elsewhere out of the resident's sight.

____ 28. When dealing with an agitated resident, avoid arguing. If tension is mounting, leave the resident and return a bit later.

____ 29. Limiting the number of choices the resident has to decide on makes the decision making process easier for the resident and lets them keep some independence.

____ 30. Encourage short afternoon naps and late bed times if residents are early risers.

____ 31. Too much sleep during the day causes inability to sleep at night.

____ 32. All residents should have a cold shower just before bedtime to help them relax.

____ 33. To prevent the resident from dozing during the day, provide continuous activity, particularly walking.

____ 34. Keeping a dim light on in residents' bedrooms, will keep the resident awake and add to her/his confusion.

____ 35. It is common for AD residents to accuse others of stealing.

____ 36. By labeling all residents' belongings, if they are in the wrong place, someone else will probably find and return them.

____ 37. The confused resident's habit of rummaging may be safely satisfied by providing him/her with a box or drawer containing items to be fiddled with.

____ 38. If the resident's behavior or words are causing distress for other residents GENTLY distract the AD resident or separate him/her from the other residents.

____ 39. Do not attempt to force a resident to participate in anything.

____ 40. When dealing with a resident who is having a catastrophic reaction, do not use any physical contact that may seem like restraint to the resident.

____ 41. Generally, delusions and hallucinations cannot be prevented in AD residents, but the symptoms can often be successfully managed.

____ 42. If the resident is upset by a delusion/hallucination, acknowledge the resident's feelings of fear and provide reassurance that you are there to make things right.

____ 43. Reasoning, explanation, and reality orientation will eventually convince an AD resident that the things she/he believes or feels are not real.

____ 44. Restraints usually make AD residents more agitated.

____ 45. Restraints may provide temporary protection of the resident but will not eliminate the cause of the problem behavior and may actually worsen the disorientation and agitation.

____ 46. Chemical restraints can cause increase in hallucination, combative and agitated behavior, elimination problems and improper nutrition.

47. List two types of chemical restraints:

a.

b.

48. List two types of physical restraints:

a.

b.

LESSON PLAN: 2

COURSE TITLE: CONFUSED RESIDENT CARE

UNIT III : SPECIAL CARE NEEDS

ANSWERS TO EVALUATION ITEMS:

1. a
2. c
3. d
4. b
5. a
6. b
7. d
8. e
9. f
10. h
11. g
12. i
13. T
14. T
15. T
16. T
17. F
18. T
19 T
20. F
21. T
22. F
23. T
24. T
25. F
26. F
27. T
28. T
29. T
30. T
31. T
32. F
33. T
34. F
35. T
36. T
37. T
38. T
39. T
40. T
41. T
42. T
43. F
44. T
45. T
46. T
47. The student may list any two:
    a. Sedatives
    b. Tranquilizers
    c. Hypnotics
    d. Other meds used to control behavior
48. The student may list any two:
    a. Soft restraints - wrist, ankle, waist, or chest (posey) restraints
    b. Geri chairs
    c. Sheets
    d. Anything used to physically control behavior

LESSON PLAN: 1

COURSE TITLE: CONFUSED RESIDENT CARE

UNIT IV : FAMILY DYNAMICS

SCOPE OF UNIT:

This unit discusses the role of the CNA when interacting with the confused resident's family. To make the information in this unit effective and meaningful, it is strongly recommended that a family member of an AD resident be invited to speak to the class about the feelings and concerns of family members when making the decision to place their loved one in a long-term care facility, and the effects of Alzheimer's disease on the family.

INFORMATION TOPIC: IV-1 OR DEMONSTRATION:

FAMILY DYNAMICS
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Identify the importance of open lines of communication with the family members of the AD resident.
2. Recognize the importance of making the family members' visit as pleasant as possible.
3. Identify the family members' need to receive information about the resident's status and plan of care.
4. Identify the benefits in receiving information from the family concerning the resident's past history and behavior.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Working with Families
2. Guest Speaker

INFORMATIONAL ASSIGNMENT: (Student)

Read this lesson prior to class and be prepared to discuss the information presented.

REFERENCES: (Instructor's Additional Information)

Alzheimer's Disease and Related Disorders Association, Inc. The Caregiver's Guide. St. Louis: ADRDA, 1988.

Alzheimer's Disease and Related Disorders Association, Inc. Working with the Family. Cleveland: ADRDA.

Greater New York Hospital Foundation, Inc. AIDS and Alzheimer's Disease: A Training Manual for Health-Care Teams about Coping with Chronic and Terminal Illnesses. New York: Greater New York Hospital Foundation, Inc., 1988.

INTRODUCTION:

The nurse assistant must not only be alert to the needs of the AD resident, but must also be aware of the needs of the resident's family. The family member(s) may have been the sole caregiver(s) for the AD resident for several years before turning that responsibility over to someone else, usually only after a great deal of agonizing and soul-searching. Arriving at the decision to send a loved one to a long-term care facility can be both a relief and a source of anxiety. The nursing staff needs the residents' families as much as they need the staff. Both can benefit from frequent and open communication. Families can offer a wealth of information regarding the resident's idiosyncracies and past life patterns. Likewise, staff can supply helpful information on alternate management techniques and explain the predictable changes through which the resident progresses as a result of the disease process.

LESSON PLAN: 1

COURSE TITLE: CONFUSED RESIDENT CARE

UNIT IV : FAMILY DYNAMICS

OUTLINE: (Key Points)

NOTE TO INSTRUCTOR: This unit may be broken into two sessions. It is recommended that for the first session a guest speaker, who is a family member of an AD resident, be invited to speak to the class about his/her experience as a caregiver at home and the experience of deciding to institutionalize his/her loved one. The second session can then be devoted to the following lesson.

I. The Importance of Open Lines of Communication with the AD Resident's Family

   A. Discuss with the resident's family member(s) the value of working together and the concept of a partnership among the staff of the long-term care facility, the resident, and his/her family. Encourage the family to ask questions and assist them in obtaining answers.

   B. The family member(s) may have been doing total care of the resident at home for a very long time and therefore is familiar with the resident's likes and dislikes. Acknowledging the family member(s) as an invaluable source of information will help him/her with changing roles. He/she may be feeling lost; having a lot of time on his/her hands now that the AD resident is in the LTC facility.

   C. The primary family member may have mixed feelings concerning the resident and his/her placement in a LTC facility. Be supportive and understanding of the family member venting his/her feelings. Do not be judgmental. (II-1)

   D. Express interest in the resident's past history and make an effort to spend time with the family member(s) to share information.

II. Making the Family Member's Visit Pleasant

   A. Explain the procedures and routines of the facility. If there are activities in the daily care routine in which the family members can participate, encourage them to do so. This will allow them to become familiar with the program and learn how the resident is spending the day.

B. Some family members may be reluctant to visit the resident. They may wish to remember the resident as he/she once was. Help to show them the value of their visit (for example, pointing out how the resident smiles at them). Remember, however, that the visit may be very difficult for this family member.

III. Relaying Information to the Family Member(s) (HO 1)

A. Within your role, explain changes, both physical and behavioral which are occurring as a result of the disease process. Refer any questions that you are not qualified to answer to your supervisor. (II-2)

B. Help the family to understand that the behavioral problems the resident may be exhibiting are a result of the illness.

C. Remind the family that due to the resident's communication problems, he/she may understand more than he/she is able to express.

D. Within your role as a CNA, discuss the therapeutic aspects of the program and the resident's adjustment to the program.

NOTE: If you are asked any questions by a family member that you are not qualified to answer, seek assistance from your supervisor. Review Unit I, Lesson 3 of Nurse Assistant in a Long-Term Care Facility manual to review resident's rights and how to avoid violating them. (II-3)

IV. Requesting Information from the Family Concerning Past History and Behavior (HO 1)

A. The request for this information demonstrates your interest in the resident and that you recognize the importance of the resident's past history.

B. Past history of the resident (II-4)

1. Occupation/employment
2. Hobbies
3. Family
4. Habits
5. Likes and dislikes

C. Behavior management - the family may be able to provide information regarding management techniques they have used with the resident, including what has been successful or unsuccessful in past situations

D. Family members often may feel that they have no control over the LTC facility situation. By allowing them to share information and relate past experiences about the resident, they will feel that they are part of the total picture and that their input is valued by the health care team.

V. Summary and Conclusion

A. The importance of open lines of communication with the AD resident's family

B. Making the family member's visit pleasant

C. Relaying information to the family member

D. Request information from the family concerning past history and behavior

The staff should remember that the AD resident's family are important members of the health care team and an invaluable source of information regarding the resident. Remember that the health care team needs the family as much as the family needs the health care team. [illegible]th can benefit from frequent and open communication.

LESSON PLAN: 1

COURSE TITLE: CONFUSED RESIDENT CARE

UNIT IV : FAMILY DYNAMICS

INTERACTION ITEMS:

1. What feelings might a primary family member experience as a result of placing their spouse or parent in a LTC facility?

2. What type of questions about the resident should you refer to your supervisor?

3. Why is it important to always be mindful of resident's rights? Which ones could be violated by the CNA when answering questions about the resident or the resident's program?

4. What are some aspects of the resident's life history that might be useful to the CNA?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Arrange for a family member of an AD resident to speak to the class about the Alzheimer's disease from the family member's perspective. Individuals in your community who would be willing to speak openly with the class may be identified through your local ADRDA chapter or support group, other LTC facilities, or a local office of the Division of Aging. The speaker should relate experiences of caring for the resident at home and feelings upon admitting the resident to the LTC facility. Students should feel free to ask questions of the speaker. Students should later be allowed to evaluate this experience.

2. An alternative to a inviting a guest speaker would be to arrange for the class to attend an AD support group meeting.

LESSON PLAN: 1

COURSE TITLE: CONFUSED RESIDENT CARE

UNIT IV : FAMILY DYNAMICS

EVALUATION ITEMS:

For each of the following, write "T" if the statement is true, or "F" if it is false.

____ 1. One problem with opening the lines of communication with the family members of the AD resident is that they might ask questions.

____ 2. It is important to discuss with the family member(s) the value of working together and the concept of forming a partnership in caring for the resident.

____ 3. The resident's past history is of no importance to the LTC caregivers at all.

____ 4. Conversations with the resident's family have value by allowing family members who have been caring for the AD resident at home to identify the resident's likes and dislikes to the caregivers at the LTC facility.

____ 5. AD resident's family members sometimes need to vent their feelings in a supportive, understanding atmosphere.

____ 6. The nurse assistant should discourage family members from participating in activities which are part of the daily care routine for the AD resident.

____ 7. The resident's family should be informed that their conversation and input regarding the resident's needs is of no importance now that the resident is in a LTC facility.

____ 8. The family member who is not able to visit very often should be told that his/her presence is of no value to the resident and that he/she is actually in your way.

____ 9. It is acceptable for caregivers to help family members to understand that behavior problems the resident may be exhibiting are results of the illness.

____ 10. It is helpful to the resident's family for you to discuss therapeutic aspects of the program and the resident's adjustment to the program, as long as this is within your role as the CNA.

11. What information about the resident would be helpful for the family member to share with the health care team? (Circle the letter of the correct answer.)

a. Occupation/employment
b. Likes and dislikes
c. Hobbies, habits, family members
d. All of the above

LESSON PLAN: 1

COURSE TITLE: CONFUSED RESIDENT CARE

UNIT IV : FAMILY DYNAMICS

ANSWERS TO EVALUATION ITEMS:

1. F
2. T
3. F
4. T
5. T
6. F
7. F
8. F
9. T
10. T
11. d

HO 1

WORKING WITH FAMILIES

What Staff Can Tell Families

About program routine

That they are welcome to visit and participate in the program

That you are interested in the resident

What specific activities they might participate in with the resident

Information about the disease process

Interpret changes that are occurring

Therapeutic changes

Short-term goals for the resident

Plans for the resident and how you will help implement them

Resident's adjustment to the program

Signs of positive change

Value of caregiver's visits

Strengths you see in the resident

Friendships, relationships that have been established

What Families Can Tell Staff

Cultural background

Spiritual beliefs

Previous occupation(s)

Educational background

Hobbies

Area where resident spent most of life

Family/marriage

Children's names, ages, jobs, locations

Grandchildren

Siblings

Special friends

Food likes and dislikes

Resident's attitudes about losses, changes

Resident's expectations of the placement

Effective behavior management techniques used with the resident in past for episodes of disruptive behavior

LESSON PLAN: 1

COURSE TITLE: CONFUSED RESIDENT CARE

UNIT V : STRESS

SCOPE OF UNIT:

The purpose of this unit is to make the caregiver aware of the signs, causes, and effects of stress that is intrinsic to working with the confused resident on a daily basis. Participants will experience and practice relaxation techniques that can assist him/her in dealing with the stressful work environment.

INFORMATION TOPIC: V-1 OR DEMONSTRATION:

STRESS MANAGEMENT FOR THE CAREGIVER
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Define terms related to stress.
2. Identify indicators of stress.
3. Define the two dimensions of stress.
4. List the three categories of symptoms of stress and one example from each.
5. Differentiate between arousal response and inhibition response to stress.
6. List techniques that can be employed to reduce stress.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Symptoms of Stress
2. HO 2: Stress Log Sheet
3. HO 3: Techniques for Managing Stress
4. Relaxation audio tape - Recommended: LETTING GO OF STRESS. Available from Audio Editions, P.O. Box 998, Burlingame, CA 94011. Write or call toll free (800) 233-4261 for ordering information. Catalog #L14123; ISBN 0-88690-023-9.

INFORMATIONAL ASSIGNMENT: (Student)

Read this lesson prior to class and be prepared to discuss the information presented.

REFERENCES: (Instructor's Additional Information)

Gardenswarts, Lee and Anita Rowe. Stress Awareness. California: Hospital Satellite Network and Department of Continuing Education in Health Sciences, UCLA Extension. CE AHP 8653. 1987.

Unwinding the Spring: Your Guide to Stress Management. Hospital Satellite Network. Refer to the following publication numbers: PT ED 0426, PT ED 0427, PT ED 0428, PT ED 0429, PT ED 0430, PT ED 0539

INTRODUCTION:

The CNA working with the confused resident experiences daily stress. This is a difficult environment in which to work. Stress can affect the physical, emotional, and mental well-being of any individual. The cost of stress in any work setting, including the hospital or long-term care facility, results in absenteeism, low productivity, and illness. By learning how to cope with stress, individuals are taking the first step in their commitment to stay healthy, vital and energetic, both on and off the job. The discussion that follows describes the various aspects of stress and explains some simple tools individuals may use to cope with their own stress as well as that of others.

LESSON PLAN: 1

COURSE TITLE: CONFUSED RESIDENT CARE

UNIT V : STRESS

OUTLINE: (Key Points)

NOTE TO INSTRUCTOR: Recommended length of time for this lesson is 90 minutes. This will allow 30-45 minutes to actually practice some relaxation techniques.

I. Terms and Definitions

- A. Distress - "bad" stress
- B. Eustress - "good" stress
- C. Hyperstress - too much stress
- D. Hypostress - too little stress
- E. Stress - inner pressure

II. Indicators of Stress

- A. Various body sensations (II-1)
  - 1. Burning in stomach
  - 2. Tightness in neck and throat
- B. Emotional responses (II-2)
  - 1. Scared
  - 2. Angry
  - 3. Numb
  - 4. "Spaced out"
- C. Those under stress should try to evaluate specific feelings and thoughts about themselves and about the problems they are facing.

III. Dimensions of Stress

A. Everyone experiences some of the same conditions, however, they do not have the same stress level. What makes events in their lives eustressful or distressful depends on their perceptions.

B. Eustress - good stress

1. Is associated with joy, exhilaration, and excitement

2. Feeling a person gets after being asked to work on a challenging project

3. Getting to do something he or she only dreamed about participating in

4. The sense of joy mixed with the knowledge of accomplishment is the feeling of eustress

5. Without any kind of energy, life would be bland and flat

6. Eustress is not harmful

C. Distress - bad stress

1. Anxiety-producing stress

2. Is associated with pressure and tension

3. Can lead to physical problems

   a. Coronaries

   b. Artery disease

   c. Ulcers

   d. High blood pressure

4. All distress shares a conscious or unconscious presumption of harm.

5. Some examples of distress

   a. "To do" list which remains eternally long

   b. It is April 15th and your taxes are not done

   c. A blow-up with your boss

        - d. Poor performance review at work
    - 6. Distress is damaging
- D. Hypostress - too little stress
    - 1. Bored
    - 2. Not enough activity to keep stimulated
    - 3. State of lethargy
- E. Hyperstress - too much stress
    - 1. Overwhelmed
    - 2. What might be the right pace for one may be too fast (or too slow) for someone else

IV. Symptoms of Stress (HO 1) - persons who are able to detect their own symptoms and connect them to the source of distress are better able to monitor and control the effects of too much stress. There are three categories of symptoms:

- A. Physical
    - 1. Insomnia
    - 2. Overeating
    - 3. Tightness in the neck
- B. Emotional
    - 1. Irritability
    - 2. Angry outbursts
    - 3. Feelings of worthlessness
    - 4. Depression
    - 5. Suspiciousness
- C. Mental
    - 1. Forgetfulness
    - 2. Preoccupation
    - 3. Lack of concentration

4. Distorted perception

5. Reduction in interest (II-3, II-4)

V. Physiological Responses to Stress (HO 2)

A. Arousal response (general adaptation syndrome)

1. Alarm stage - fight/flight

2. Resistance stage - being behind the "eight ball"

3. Exhaustion - physical illness

B. Inhibition response

1. Possum response - "roll over and play dead" condition

2. Opposite of general adaptation syndrome

3. Instead of adrenaline pumping, response is listlessness and condition of "shut-down"

4. Depressed

5. Lethargic

6. Isolated

VI. Techniques for Reducing Stress (HO 3)

A. View change as inevitable and as a positive,energizing force.

B. Remember, your perception influences whether events are eustressful or distressful to you. Look at situations realistically.

C. Know your limitations and do not go beyond them.

D. Learn to say no.

E. Ask for help when you need it.

F. Pay attention to your body's stress signals.

G. Practice deep breathing when you feel stressed.

H. Try to identify sources of unnecessary stress and eliminate them.

I. Remember to plan time in your schedule for yourself, and spend it having fun.

J. Exercise regularly. Physical activity helps to offset the effects of stress. Some fitness activities such as walking or bicycle riding can be easily incorporated into one's daily routine.

K. Practice total body relaxation using a relaxation tape.

VII. Summary and Conclusion

A. Terms and definitions

B. Indicators of stress

C. Dimensions of stress

D. Symptoms of stress

E. Physiological responses to stress

F. Techniques for reducing stress

Remember that stress is a physiological event that is psychologically triggered. It takes its toll on the body, but it starts in the brain. It is important to learn more about the role of perception in determining stress and methods by which attitude may be adjusted in order to diminish sources of stress in life.

LESSON PLAN: 1

COURSE TITLE: CONFUSED RESIDENT CARE

UNIT V : STRESS

INTERACTION ITEMS:

1. How does your body feel when you are under stress?
2. How do you feel when under stress?
3. What symptoms do you see in others? At home? At work?
4. What events do you connect with your symptoms?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Ask students to fill out Handout 2. Allow about 5 minutes to complete this and then discuss their responses as a group.
2. Choose an appropriate relaxation tape to use with the class and be sure to arrange for a tape player to use with this activity. Ask students to sit erect in a chair, lie down on the floor, or assume any position that is relaxing and comfortable for them. Ask them to close their eyes and relax, and focus on the relaxation tape, nothing else. The instructor should control the environment by eliminating any chance of interruption or distraction. A quiet, calm atmosphere is essential to this process. Dim all the lights in the room. Turn on the tape and relax with the students during the tape. After the tape is complete, allow students several minutes to reorient to the classroom atmosphere before turning up the lights. Allow students time to talk about how the tape affected them. Note that many people never experience a fully relaxed state.

LESSON PLAN: 1

COURSE TITLE: CONFUSED RESIDENT CARE

UNIT V: STRESS

EVALUATION ITEMS:

For each of the following, write "T" if the statement is true or "F" if it is false.

____ 1. Hypostress refers to too much stress.

____ 2. Hyperstress refers to too little stress.

____ 3. A burning feeling in your stomach can be a sign of distress.

____ 4. Soreness in the shoulders can be a sign of distress.

____ 5. You are feeling angry over the demands your boss just made on you. You are feeling distress.

____ 6. Eustress is bad stress and should be avoided.

____ 7. Distress is good stress and helps make our lives fun, interesting, and challenging.

8. List the three categories of symptoms of stress response and give one example of each.

    a.

    b.

    c.

9. Differentiate between the two physiological responses to stress: arousal response and inhibition response.

10. List three methods that can be employed for reducing stress.

a.

b.

c.

LESSON PLAN: 1

COURSE TITLE: CONFUSED RESIDENT CARE

UNIT V : STRESS

ANSWERS TO EVALUATION ITEMS:

1. F
2. F
3. T
4. T
5. T
6. F
7. F
8. The student must list each category listed below and any one example under each category.
   a. Physical
      1. Insomnia
      2. Overeating
      3. Tightness in the neck
   b. Emotional
      1. Irritability
      2. Angry outbursts
      3. Feelings of worthlessness
      4. Depression
      5. Suspiciousness
   c. Mental
      1. Forgetfulness
      2. Preoccupation
      3. Lack of concentration
      4. Distorted perception
      5. Reduction in interest
9. Arousal response (general adaptation syndrome) requires expenditure of adrenaline and consists of the alarm stage, resistance stage, and exhaustion; the inhibition response is almost the opposite type of response in that it is also called the possum response (roll over and play dead state) where one becomes listless and shut-down, may feel depressed, lethargic, isolated
10. The student may list any three of the following:
    a. View change as inevitable and as a positive, energizing force in your life
    b. Remember, your perception influences whether events are eustressful or distressful to you. Look at situations realistically.
    c. Know your limitations and do not go beyond them.
    d. Learn to say, "NO!"
    e. Ask for help when you need it.
    f. Pay attention to your body's stress signals.
    g. Practice deep breathing when you feel stressed.

h. Try to identify sources of unnecessary stress and eliminate them.
i. Remember to plan time in your schedule for yourself, and spend it having fun.
j. Exercise regularly. Physical activity helps to offset the effects of stress.
k. Practice total body relaxation using a relaxation tape.

HO 1

SYMPTOMS OF STRESS

The presence of stress in our lives is a fact that will never change. Almost every day we are called upon to deal with stressful situations, both on the job and at home. Some stress can be handled and hardly noticed. Too much stress may produce symptoms in three distinct areas:

- Physical
- Emotional
- Mental

You can learn to be aware of your stress levels by monitoring symptoms of stress that you may notice. Once you are aware of stress symptoms, you are better equipped to deal with them by using some of the stress management techniques discussed in class.

Physical symptoms . . .

- Heart beats faster
- Tendency to overeat
- Tendency to smoke excessively
- Blood pressure goes up
- Tightness in chest and breathing seems difficult
- Palms get sweaty
- Nervous tics and twitching
- Neck and shoulder muscles get tight
- Backaches
- Headaches
- Nausea/vomiting
- Irregular sleep or inability to sleep
- Loss of appetite
- Tired all the time
- Susceptible to minor illnesses
- Flare-ups of herpes simplex (cold sores)

Emotional symptoms . . .

- Outbursts of anger
- Sense of worthlessness
- Feelings of depression
- Suspicious of others
- Jealous of others
- Overall feelings of restlessness
- Anxiety
- Tendency to withdraw
- Aggressiveness
- Episodes of crying
- Hypercritical of self and others
- Chronic boredom

Mental symptoms . . .

- Thoughts are preoccupied, have trouble staying focused on task at hand
- Tendency to be forgetful
- Errors in math calculations and grammar usage
- Inability to judge distance accurately
- Inability to concentrate
- Constant worry
- No attention to details
- Loss of interest in many things
- Tendency to want to live in the past

HO 2

STRESS LOG

Use the stress log to increase your awareness of stress levels. Chart specific situations, problems, or events that you found stressful and identify the stress symptom(s) you experienced because of it.

Stressful Situation	Physical Symptoms	Emotional Symptoms	Mental Symptoms
1.			
2.			
3.			

HO 3

TECHNIQUES FOR MANAGING STRESS

Try using the following techniques to control the stress levels in your life.

- View change as inevitable and as a positive, energizing force in your life.
- **Remember,** your perception influences whether events are **eustressful** or distressful to you. Look at situations realistically.
- Know your limitations and do not go beyond them.
- Learn to say no.
- Ask for help when you need it.
- Pay attention to your body's stress signals.
- Practice deep breathing when you feel stressed.
- Try to identify sources of unnecessary stress and eliminate them.
- Remember to plan time in your schedule for yourself, and spend it having fun.
- Exercise regularly. Physical activity helps to offset the effects of stress.
- Practice total body relaxation using a relaxation tape.

LESSON PLAN: 1

COURSE TITLE: CONFUSED RESIDENT CARE

UNIT VI : SPECIAL RESOURCES

SCOPE OF UNIT:

The purpose of this unit is to provide resource information for the CNA. As the CNA continues to care for the resident and interact with the resident's family, it is important to have access to additional and updated information regarding the confused elderly and Alzheimer's disease.

INFORMATION TOPIC: VI-1 OR DEMONSTRATION:

SPECIAL RESOURCES
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT WILL BE ABLE TO:

1. Locate national, state, and local resources for update information.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: ADRDA Chapters in Missouri

2. HO 2: Area Agencies on Aging for Missouri

INFORMATIONAL ASSIGNMENT: (Student)

Read this lesson prior to class and be prepared to discuss the information presented.

REFERENCES: (Instructor's Additional Information)

Area Agencies on Aging. Missouri Department of Social Services, Division of Aging, P.O. Box 1337, Jefferson City, MO 65102

ADRDA St. Louis Chapter, 9378 Oliver St. Road, Suite 110, St. Louis, MO 63132

ADRDA Kansas City Chapter, Box 12113, Overland Park, KS 62112

Washington University School of Medicine, Department of Memory and Aging Project, Box 8111, 660 South Euclid Ave., St. Louis, MO 63110

INTRODUCTION:

The CNA who is trained to manage the confused resident is a valuable resource person to family members and other members of the health care team. Therefore, it is important for the CNA to stay current on the latest information regarding Alzheimer's disease that may impact on the resident, the family, and other caregivers.

LESSON PLAN: 1

COURSE TITLE: CONFUSED RESIDENT CARE

UNIT VI : SPECIAL RESOURCES

OUTLINE: (Key Points)

INSTRUCTOR NOTE: The resources discussed in this lesson refer to both national and state levels. Check agency listings in your community to identify resources available in your area.

I. National Organizations and Research Centers

   A. Alzheimer's Disease and Related Disorders Association (ADRDA), Inc. National Headquarters, 70 East Lake Street, Chicago, IL 60601 (312) 853-3060

      1. Founded in 1980 as a privately-funded national voluntary health organization

      2. Headquartered in Chicago, ADRDA has more than 1,000 support groups and 150 chapters and affiliates nationwide.

      3. ADRDA's Board of Directors is comprised of business leaders, health professionals, and family members.

      4. A medical and scientific advisory board consults and monitors issues related to AD.

      5. ADRDA's four major goals:

         a. Support research of causes, treatments, cures, and prevention of AD

         b. Provide family support through local chapters, affiliates, and family support groups which offer assistance to afflicted families

         c. Stimulate education and public awareness (laypersons and professionals) on Alzheimer's disease

         d. Advocacy; encourage legislation at federal, state, and local levels that responds to the needs of Alzheimer's disease patients and family members (II-1)

6. Other services of ADRDA

   a. Promotes public awareness

   b. Maintains liaisons with government agencies and national professional organization

   c. Stimulates family support activities

   d. Administers research grant programs to initiate new investigations into the cause(s), prevention, and cure of Alzheimer's disease

   e. Serves as a clearinghouse for information; publishes quarterly newsletter

   f. Sponsors a month-long public awareness campaign for National Alzheimer's Disease Awareness Month in November

   g. Alzheimer's Disease International was formed in 1984 to share program and research developments on Alzheimer's disease world-wide

   h. HOTLINE: A national 24-hour HOTLINE provides information and links families who need assistance with nearby chapters and affiliates. Those interested in help may call 800-621-0379.

B. National Institute on Aging

1. Many families of Alzheimer's victims are interested in participating in Alzheimer's disease research. (II-2)

2. The National Institute on Aging currently funds Alzheimer's disease research centers. Each center has its own unique area of research.

3. Families may contact these programs directly in order to obtain information about the program's special area of research, the research protocol, and the center's specific instructions concerning the preparation and delivery of the brain tissue to the program.

II. State Resources

A. ARDRA chapters in Missouri (HO 1)

INSTRUCTOR NOTE: Refer students to the appropriate chapter for your area

B. Area Agencies on Aging (HO 2)

INSTRUCTOR NOTE: Refer students to the appropriate agency for your area

III. Special Care Units - Community Resources

INSTRUCTOR NOTE: Local resources change frequently, therefore the instructor should contact the local Division of Aging or local ADRDA chapter for information regarding facilities with special care units for Alzheimer's residents, community resources, support groups, and organizations in your specific area. It is incumbent on the instructor to provide information specific to the area in which this training program is carried out.

A. Special care units for Alzheimer's residents

B. Community resources, including respite care

C. Support groups

D. Local organizations

IV. Summary and Conclusion

A. National organizations - including research centers

B. State resources

C. Special care units - community resources

LESSON PLAN: 1

COURSE TITLE: CONFUSED RESIDENT CARE

UNIT VI : SPECIAL RESOURCES

INTERACTION ITEMS:

1. Why is advocacy an important issue?
2. Why are some families interested in participating in research?

CLASSROOM, LABORATORY, OR OTHER ACTIVITIES:

1. Have students contact the local chapter of ADRDA and request informational publications addressing aspects of providing care for the Alzheimer's resident.

LESSON PLAN: 1

COURSE TITLE: CONFUSED RESIDENT CARE

UNIT VI: SPECIAL RESOURCES

EVALUATION ITEMS:

For each of the following, write "T" if the statement is true, or "F" if it is false.

____ 1. Information regarding location of the closest ADRDA chapter can be obtained from the National ADRDA 24-hour hotline.

____ 2. Information regarding local support group, special care facilities, and information on ADRDA can be obtained through the local chapter of ADRDA or the local chapter of the Division of Aging.

LESSON PLAN: 1

COURSE TITLE: CONFUSED RESIDENT CARE

UNIT VI : SPECIAL RESOURCES

ANSWERS TO EVALUATION ITEMS:

1. T
2. T

ADRDA CHAPTERS IN MISSOURI

ADRDA - St. Louis Chapter
9378 Olive St. Road
Suite 110
St. Louis, MO 63132

(314) 432-3422

ADRDA - Kansas City Chapter
Box 12113
Overland Park, KS 66204

(816) 942-7130

ADRDA - Mid-Missouri Chapter
609 Nebraska Ave.
Suite 12
Columbia, MO 65201

(314) 443-8665

ADRDA - Southwest Missouri Chapter
3647 Sugar Hollow
Springfield, MO 65804

(417) 883-9052

ADRDA - Northwest Missouri Chapter
608 South 10th
Bethany, MO 64424

(816) 425-8854

HO 2

AREA AGENCIES ON AGING FOR MISSOURI

Southwest Missouri Office of Aging
317 Park Central East
Box 1805 SSS
Springfield, MO 65805

(417) 862-0762

Southeast Missouri AAA
1301 No. Kingshighway
Cape Girardeau, MO 63701

(314) 335-3331

District III AAA
604 North Maguire
P.O. Box 556
Warrensburg, MO 64093

(816) 747-3107

Northwest Missouri AAA
P.O. Drawer G
401 W. Jackson
Albany, MO 64402

(816) 726-3800 or
726-3083

Northeast Missouri AAA
705 E. LaHarpe
P.O. 1067
Kirksville, MO 63501

(816) 665-4682

Central Missouri AAA
609 Nebraska
Columbia, MO 65201

(314) 443-5823

Aging Program
Mid-American Regional Council
20 West 9th Street
7th Floor
Kansas City, MO 64105

(816) 474-4240

Mid-Eastern Missouri AAA
Kimberly Bldg., Suite 212
2510 S. Brentwood Boulevard
Brentwood, MO 63144

(314) 962-7999

City of St. Louis
Department of Human Services
12th Floor, Civil Courts Bldg.
St. Louis, MO 63101

(314) 622-4891

Region X AAA
705 Illinois, Suite 126
Joplin, MO 64801

(417) 781-7562

PRETEST - CONFUSED RESIDENT CARE
(Developed by ADRDA St. Louis Chapter)

For each of the following, write "T" if the statement is true, or "F" if it is false.

____ 1. Everyone becomes "senile" sooner or later if he/she lives long enough.

____ 2. What we say is more important to a demented resident than how we say it.

____ 3. Alzheimer's disease (AD) can cause a person to lose control over her/his emotions.

____ 4. By keeping calm and speaking in a slow, soothing voice we can help a demented resident regain control over agitation.

____ 5. AD can cause a person to have trouble walking or eating.

____ 6. Residents with dementia become easily upset in a noisy, crowded environment.

____ 7. An AD resident may become more confused in a new environment.

____ 8. Residents with dementia need short, one-step-at-a-time directions.

____ 9. An infection may cause an AD resident to become more confused.

____ 10. Families still feel responsibility toward the resident when he/she is in a nursing facility.

____ 11. The decision to place the resident in a long-term care facility is a great relief to the family.

____ 12. A caregiver should establish a relationship with the family and build their trust and confidence.

____ 13. If I (as the caregiver) feel angry toward a resident after a combative episode, I am experiencing normal feelings.

____ 14. If I am starting to feel more tired than usual or having frequent headaches, I may be feeling the symptoms of stress.

____ 15. Mental confusion is an inevitable, incurable consequence of old age.

ANSWERS TO PRETEST

1. F
2. F
3. T
4. T
5. T
6. T
7. T
8. T
9. T
10. T
11. F
12. T
13. T
14. T
15. F

POSTTEST - CONFUSED RESIDENT CARE

For each of the following, write "T" if the statement is true, or "F" if it is false.

____ 1. Dementia is a another name for Alzheimer's disease.

____ 2. Dementia is characterized by a decline from a previously attained intellectual level.

____ 3. Dementia is usually long-lasting in most cases, although some forms of dementia may be arrested or reversed.

____ 4. AD affects an estimated 2.5 million American adults.

____ 5. AD is the most common form of dementing illness.

____ 6. AD is the fourth leading cause of death in adults.

____ 7. Alzheimer's disease is a normal part of aging.

____ 8. AD is a physical disease of the brain.

____ 9. AD is a mental illness.

____ 10. With AD, memory problems and decline in personal care may affect all residents.

____ 11. With AD, memory loss is sudden in onset.

____ 12. With AD, the resident will experience personality changes, difficulty in learning, and loss of language skills.

____ 13. Suspected causes of Alzheimer's disease are slow virus, chromosomal defect, immunologic changes, and neurotransmitter deficiency.

____ 14. A family history of Alzheimer's disease is an increased risk factor for family members.

____ 15. The risk factor for Alzheimer's disease increases with age.

____ 16. Multi-farct dementia is characterized by sudden onset.

____ 17. Cooking in aluminum pots and using aluminum foil can cause AD.

____ 18. In the first stage of AD the resident may exhibit difficulty focusing attention.

____ 19. In the first stage of AD, the resident may withdraw from social interaction.

____ 20. Loss of short-term memory is exhibited in the first stages of AD.

____ 21. In the second stage of AD the resident will exhibit obvious deficits in memory.

____ 22. An AD resident complains that no one has taken care of him all day, when in fact you have spent several hours providing care for the resident. This behavior is characteristic of the second stage of AD.

____ 23. Hesitation in verbal responses is exhibited in the second stage of AD.

____ 24. The AD resident is who disoriented to place and person, has decreased in motor skills, and is often found wandering, exhibits behavior common to the third stage of AD.

____ 25. In the third stage, the AD resident may not recognize his or her own reflection.

____ 26. Catastrophic reactions are common in stage three.

____ 27. Stage four is the terminal stage of AD

____ 28. An autopsy is NOT the only method to correctly diagnosis Alzheimer's disease.

____ 29. There are no other diseases that mimic Alzheimer's disease.

____ 30. There is no cure for AD available at this time.

____ 31. Good planning and medical and social management can ease the burdens on the resident and the family.

____ 32. Physical exercise and social activities are not important to the AD resident.

____ 33. A calm and well-structured environment may help the AD resident to maintain as much comfort and dignity as possible.

____ 34. The resident who can't get the toothpaste on the toothbrush should not be allowed to brush his/her own teeth.

____ 35. Tell resident, Mrs. Smith, that she did a good job of sitting on the toilet and going to the bathroom, even if she forgot to pull her underwear down.

____ 36. The AD resident's ability to follow directions and make judgements deteriorates regardless of what is done, so practicing special care techniques is a waste of caregivers' time.

____ 37. Deterioration is part of the disease process, and will occur no matter how good the care is.

____ 38. Caregivers can make the residents' lives better and more comfortable with good care.

____ 39. Concentrate on what AD residents CAN DO, not what they cannot do.

____ 40. Fluids are often withheld in an attempt to control incontinence, with the end result being dehydration.

____ 41. Residents need to change their behavior and responses, and the caregiver does not.

____ 42. A structured routine is not important for the AD resident.

____ 43. Soothing music has a positive effect on residents.

____ 44. Heavy silverware, especially spoons, should be used by the resident as a tactile reminder that he/she is eating.

____ 45. To avoid dehydration and limit incontinence problems, encourage fluids during the daytime hours. Restrict fluids a few hours before bedtime.

____ 46. AD residents are often afraid of bathing.

____ 47. Undressing in front of others, and having others touch and wash their aging bodies is not embarrassing for most residents.

____ 48. If residents are too confused to understand what the caregiver is doing, they may think the caregiver is going to hurt them.

____ 49. Identify the resident's normal bathing routine to make the process more familiar to the resident and less frightening.

____ 50. Clothing with elastic bands and simple closures should be used to make it easier for AD residents to continue some independence in their self-care

____ 51. Breaking complicated tasks down into smaller tasks makes it easier for the resident to complete each step of the process.

____ 52. Establishing a regular routine and doing everything in exactly the same way will not benefit the resident but is valuable in that it utilizes the caregiver's time more effectively.

____ 53. AD residents have the ability to imitate. This can be of value to the caregiver when modeling self-care tasks to the resident.

____ 54. If the resident is afraid of bathing, placing only two or three inches of water in the tub might help the resident to feel more secure.

____ 55. Many AD residents may not understand that their discomfort is because they have to go to the bathroom.

____ 56. If the resident awakes during the night to go to the bathroom, he/she may be too confused or frightened to find the bathroom.

____ 57. When a resident wanders, he/she may be looking for a bathroom.

____ 58. All AD residents should be taken to the bathroom every two hours while they are awake.

____ 59. A picture of a commode on the bathroom will probably be of no help to any resident who cannot remember where the bathroom is located.

____ 60. Having residents avoid fluids after 9 p.m. will help prevent waking at night to use the bathroom.

____ 61. A resident's biggest problem with getting dressed is the number of decisions that must be made.

____ 62. Residents should be encouraged to dress in street clothes as staying in pajamas makes them feel sick and unmotivated.

____ 63. Complications from immobility often lead to death with AD residents. They should be given as much exercise as possible.

____ 64. Keeping the AD resident in bed causes sensory deprivation and increases confusion.

____ 65. A safe environment is critically important to the AD resident because of the tendency to wander and the problem of cognitive dysfunctioning.

____ 66. All AD residents should wear ID bands with name, phone, and a statement of their memory impairment in case they get lost.

____ 67. Avoid restraints if at all possible as they usually cause the resident to become more agitated.

____ 68. Memory loss is going to continue to deteriorate, but there are some environmental changes that can maximize the existing memory capabilities.

____ 69. Keeping frequently used personal belongings in the same place all the time encourages remembering, and allows residents to care more for themselves since the locations of items become ingrained.

____ 70. AD residents easily forget who caregivers are, and an introduction helps them to identify the caregiver as a friend.

____ 71. Residents must be approached in a calm manner no matter how difficult the circumstances. The resident "feels" emotions even though they might not know what is wanted.

____ 72. Excessive noise, light, and movement do not affect the AD resident because they do not really understand what is happening around them.

____ 73. Many of the AD resident's behavior abnormalities can be traced to a basic need that must be met.

____ 74. AD residents do not require exercise. They are much too weak and confused to do any exercise at all.

____ 75. If a resident is pacing in a circle, interrupt this routine by placing a piece of furniture in the way, not by being abrupt and confrontational.

____ 76. Assure residents that you will take care of them; frequently residents are confused and afraid and they simply need to know that they are safe and okay.

____ 77. Caffeine does not increase restlessness.

____ 78. If wandering usually occurs at a specific time of day, restrain the resident to control wandering.

____ 79. Keep items that suggest outdoor activities and travel (overcoats, hats, etc.) stored in a closet or elsewhere out of sight. This may decrease the need to wander.

____ 80. When dealing with an agitated resident, avoid arguing. Leave the resident and return a bit later if tension is mounting.

____ 81. Limiting the number of choices the resident has makes the decision-making process easier for the resident and lets him/her keep some independence.

____ 82. Encourage short afternoon naps and late bedtimes if residents are early risers.

____ 83. If residents are late risers, avoid naps and late bedtimes. Too much sleep during the day causes inability to sleep at night.

____ 84. All residents should have a cold shower just before bed time. This will help relax them.

____ 85. To prevent dozing provide continuous activity during the day, particularly walking. Activity is important to tire residents out by nightfall.

____ 86. Keeping a dim light on in the resident's bedroom will keep the resident awake and add to his/her confusion.

____ 87. It is common for AD residents to accuse others of stealing. Remain calm and do not take this personally, but offer to help the resident to find the lost article. Do not argue about the loss.

____ 88. When dealing with a resident who is having a catastrophic reaction, do not use any physical contact that may seem like restraint to the resident.

____ 89. If the resident is upset by a delusion or a hallucination, you should acknowledge her/his fearful feelings and provide reassurance that you are there to make things right.

____ 90. Reasoning, explanation, and reality orientation will convince the AD resident that the things he/she believes or feels are not real.

____ 91. Restraints usually make AD residents more agitated.

____ 92. Restraints may provide temporary protection for the resident, but they will not take care of the cause of the problem behavior, and may worsen disorientation and agitation.

____ 93. Chemical restraints can cause increased hallucinations, combative and agitated behavior, elimination problems, and improper nutrition.

____ 94. A burning feeling in your stomach can be a sign of distress.

____ 95. Soreness in the shoulders can be a sign of distress.

____ 96. You are feeling angry over the demands your boss just made on you. You are feeling distress.

____ 97. Eustress is bad stress and should be avoided.

____ 98. Distress is good stress and helps make our lives fun, interesting, and challenging.

____ 99. Information regarding location of ADRDA chapters can be obtained from the National ADRDA 24-hour hotline.

____100. Information regarding local support groups, special care facilities, and information on ADRDA can be obtained through the local chapter of ADRDA.

ANSWERS TO POSTTEST

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BIBLIOGRAPHY

AIDS and Alzheimer's Disease: A Training Manual for Health-Care Teams about Coping with Chronic and Terminal Illnesses. Greater New York Hospital Foundation, Inc., 61 West 62nd Street, Third Floor, New York, NY 10023-7031. $66.00.

Allaire, Barbara and Robert McNeil. Teaching Patient Relations in Hospitals, the Hows and Whys. American Hospital Publishing, Inc., AHA. Catalog no. 049150.

Alzheimer's Disease and Related Disorders Association, Inc. Fact Sheet of Alzheimer's Disease. Chicago: ADRDA, Inc. National Headquarters.

Alzheimer's Disease and Related Disorders Association, In. Home Care with the Alzheimer's Patient. Chicago: ADRDA, Inc. National Headquarters, 1988.

Alzheimer's Disease and Related Disorders Association Medical and Scientific Advisory Board. Medical Evaluation of the Patient with Dementia. Chicago: ADRDA, Inc. National Headquarters, 1982.

Alzheimer's Disease and Related Disorders Association, Inc. Understanding and Caring for the Person with Alzheimer's Disease. Atlanta: ADRDA Atlanta Chapter, 1983.

Alzheimer's Disease and Related Disorders Association. Family Care Guide. ADRDA of Eastern Massachusetts in collaboration with ADRDA of Cape Cod and the Islands and ADRDA of Western Massachusetts., 1988.

Aronson, Miriam K., ed. Understanding Alzheimer's Disease: What it is, How to Cope with it, Future Directions. New York: McMillan Publishing Co., 1987.

Brody, Jane E. "Guidance in the Care of Patients with Alzheimer's Disease, Personal Health." The New York Times. November 30, 1983.

Brookdale Foundation and Brookdale Center on Aging of Hunter College. How to Start Respite Service for People with Alzheimer's and Their Families: A Guide for Community-Based Organizations. New York: The Brookdale Foundation, 1987.

Burnside, I., ed. Nursing and the Aged. New York: McGraw-Hill, 1976.

Cohen, D. and C. Eisdorfer. The Loss of Self: A Family Resource for the Care of Alzheimer's Disease and Related Disorders. New York: W.W. Norton, 1986.

Coons, D.H., et. al. A Better Life: Helping Family Members, Volunteers and Staff Improve the Quality of Life of Nursing Home Residents Suffering from Alzheimer's Disease and Related Disorders. Columbus, OH: Source for Nursing Home Literature, 1986.

Frank, J. The Silent Epidemic. Minneapolis: Lerner Publications Company, 1985.

Gardenswarts, Lee and Anita Rowe. Stress Awareness. California: Hospital Satellite Network and Department of Continuing Education in Health Sciences, UCLA Extension.

Guthrie, D. Grandpa Doesn't Know It's Me. New York: Human Sciences Press, 1986.

Gray-Vickrey, Margaret. Alzheimer's Disease: Coping with Confusion. Hospital Satellite Network and American Journal of Nursing Company. CNE 7501.

Heston, L.L. and J.A. White. Dementia--A Practical Guide to Alzheimer's Disease. New York: W.H. Freeman and Co., 1983.

Jacobs-Imber, Ellen. Lifestyle Plus 1984 Director: A Directory of Greater Kansas City Services for the Older Person. Kansas City: The Golden Age Foundation of Kansas City, 1984.

Krewson, Jacalyn. Alzheimer's Disease: Teaching Series for Health Care Providers. (Instructor's Manual). The Educational and Scientific Trust, Pennsylvania Medical Society, 20 Erford Rd., Lemoyne, PA 17043 ($47.95).

Lincoln, Elizabeth M. Choosing a Nursing Home for the Person with Intellectual Loss. New York: Burke Rehabilitation Center, 1980.

Mace, Nancy L. Sharing is Caring - Visiting the Doctor. Baltimore: ADRDA.

Mace, Nancy L. and Peter V. Rabins, M.D. The 36-Hour Day: A Family Guide to Caring for Persons with Alzheimer's Disease and Related Dementia Illness, and Memory Loss in Later Life. Baltimore: The Johns Hopkins University Press, 1981. $7.00 suggested donation.

McDowell and Lincoln. Managing the Person with Intellectual Loss at Home. White Plains, NY: The Burke Rehabilitation Center, 1980.

Menkin, Eva L. What You can do to Help Caregivers of Alzheimer's Disease Patients. Santa Barbara, CA: ADRDA.

Nee, Linda E., Understanding a Combative Patient. Washington DC: ADRDA.

Nolen, William A. *The Enigma of Alzheimer's: A Devastating Brain Disease has Doctors Baffled*. Chicago: ADRDA, Inc. National Headquarters, 1983.

Nurse Assistant in a Long-Term Care Facility. Columbia, MO: Instructional Materials Laboratory, University of Missouri - Columbia, rev. 1987.

Powell, L.S., and K. Courtice. *Alzheimer's Disease: A Guide for Families*. Reading, MA: Addison-Wesley, 1983.

Riley, Kathryn Perez and Francine Hekelman. *Training Home Health Aides in Alzheimer's Respite Care*. Cleveland: Alzheimer's Association Cleveland Chapter.

Sacks, O. *The Man Who Mistook His Wife for a Hat*. New York: Summit Books, 1985.

Scholtes, Suzette, et al. *Three Profiles Coping with Alzheimer's*. Kansas City: Greater Kansas City ADRDA.

Sommers, Tish and Laurie Shields. *Women Take Care: The Consequences of Caregiving in Today's Society*. Gainesville, FL: Triad Publishing Company, 1987.

Unwinding the Spring: Your Guide to Stress Management. Hospital Satellite Network.

Vernersch, Patricia E., et al. *Managing the Clint with Dementia: A Resource and Training Guide for Nursing Homes and Adult Day Care Centers*. New Jersey State Department of Health.

Wallis, Claudia. "Slow, Steady and Heartbreaking: Alzheimer's Disease is a Devastating Illness of Advancing Age." *Medicine Time*. July 11, 1983.

Wittenborn, Richard. "Hardening of the Arteries Causes Senility - Fact or Fiction." *Family and Friends Newsletter*. ADRDA Northern Virginia Chapter.

RESOURCES

Handbooks:

Age Words: A Glossary on Health and Aging. U.S. Department of Health and Human Services.

Alzheimer's Disease and Related Disorders Association, Inc. Respite Care Manual. Chicago: ADRDA.

Alzheimer's Disease and Related Disorders Association, Inc. The Caregiver's Guide: The Fading Mind . . . A.D. - Alzheimer's Disease. St. Louis: ADRDA, 1988.

Alzheimer's Resource Center. Caring - A Family Guide to Managing the Alzheimer's Patient at Home. New York: Alzheimer's Resource Center

Gwyther, L. Care of Alzheimer's Patients - A Manual for Nursing Home Staff. American Health Care Association and Alzheimer's Disease and Related Disorders Association, Inc.

Mace, N.L. Home and Community Services for Alzheimer's Disease, A National Conference for Families. U.S. Department of Health and Human Services and Alzheimer's Disease and Related Disorders Association, Inc.

Office of Technology Assessment, 1987. Losing a Million, Confronting the Tragedy of Alzheimer's Disease and Other Dementias. Washington, DC: U.S. Government Printing Office.

Pamphlets:

About Alzheimer's Disease. Channing L. Bete Co., Inc. 200 State Road, South Deerfield, MO 01373-0200. 1-800-628-7733.

ADRDA Fact Sheet on Alzheimer's Disease. Alzheimer's Disease and Related Disorders Association, Inc. - National Headquarters, 70 East Lake Street, Chicago, IL 60601. (312) 432-3422.

Alzheimer's Disease: Did You Know? ADRDA - St. Louis Chapter, 9378 Oliver St. Road - Suite 110, St. Louis, MO 63132. (314) 432-3422.

Alzheimer's Disease Questions and Answers. U.S. Department of Health and Human Services, Public Health Service National Institutes of Health. NIH Publication NO. 85-1646, reprinted May 1985.

An Exercise in Understanding Dementia. Jewish Center for the Aged of Greater St. Louis, 13190 South Outer 40 Road, Chesterfield, MO 63017.

Older Volunteer Service Bank. Missouri Department of Social Services, Division of Aging, P.O. Box 1337, Jefferson City, MO 65102. (314) 751-3082 or 1-800-235-5503.

Respite Care, Easing Family Caregiver Burden. ADRDA - St. Louis Chapter, 9378 Olive Street Road - Suite 110, St. Louis, MO 63132. (314) 432-3422.

St. Louis University Medical Center and Alzheimer's Disease and Related Disorders Association, Inc. Brain Bank. St. Louis University Medical Center, Division of Geriatric Psychiatry, 1221 S. Grand Blvd., St. Louis, MO 63104. (314) 577-8726.

What is Your Aging I.Q.? National Institute on Aging. U.S. Department of Health and Human Services/National Institutes of Health.

Other Publications:

The American Journal of Alzheimer's Care and Related Disorders and Research, 470 Boston Post Road, Weston, MA 02193. $52. 1989

ADRDA Newsletter. Alzheimer's Disease and Related Disorders Association, Inc. - St. Louis Chapter, 9378 Oliver Street Road, Suite 110, St. Louis, MO 63132.

A Model for the Identification of Communication Disorders in Acute and Long-Term Care Patients. Paper presented at the 41st Annual Scientific Meeting of the Gerontological Society of America. November 20, 1988.

Impact of Work Environment on Job Satisfaction: Nurses' Aides in Long-Term Care Facilities. University of Notre Dame, Department of Psychology, Hagger Hall, Notre Dame, IN 46556.

Training Home Health Aides in Alzheimer's Respite Care. Kathryn Perez Riley, Ph.D. Cleveland State University, Cleveland Ohio; Francine Hekelman, Ed.S. Case Western Reserve, Cleveland Ohio; and the Alzheimer's Association, Cleveland Chapter.

Working with the Family. Alzheimer's Disease and Related Disorders Association, 1801 Chestnut Hills Drive, Cleveland Heights, OH 44106 (216) 721-8457.

Genetic Risk of Alzheimer's Disease. Leonard L. Heston, M.D., Department of Psychiatry, University of Minnesota.

Ten Basic Strategies for Families. Alzheimer's Disease and Related Disorders Associations, Inc.

Managing the Person with Intellectual Loss at Home. 1980. The Burke Rehabilitation Center, White Plains, NY. McDowell & Lincoln.

NATIONAL INSTITUTE ON AGING PUBLICATIONS LIST

The following publications are available from the National Institute on Aging, 2209 Distribution Circle, Silver Spring, MD 20910.

NIA INFORMATION PACKET

- National Institute on Aging
- NIA Fact Sheet
- Research Advances in Aging - 1984-86
- To Understand the Aging Process: The Baltimore Longitudinal Study of Aging
- Publications List

ALZHEIMER'S DISEASE PACKET

- Differential Diagnosis of Dementing Disease
- Progress Report on Alzheimer's Disease, Vol II
- Q & A: Alzheimer's Disease
- Senility: Myth or Madness (Age Page)
- Senility Reconsidered (reprint from JAMA)

RESEARCH GRANTS AND TRAINING OPPORTUNITIES

- Research Grants Packet
- Research Training Opportunities at the NIA Gerontology Research Center

HEALTH EDUCATION AND DISEASE PREVENTION

- Accidental Hypothermia: Winter Hazard for Older People
- Answers About Aging
- Age Words: A Glossary on Health and Aging
- Exercise Program Packet
- Health Resources for Older Women
- The Menopause Time of life
- Spanish Language Health Information
- What is Your Aging IQ?

TECHNICAL REPORTS AND RESEARCH SUMMARIES

- Established Populations for Epidemiologic Studies of the Elderly: Resource Date Book
- Normal Human Aging: The Baltimore Longitudinal Study of Aging
- Personnel for Health Needs of the Elderly Through Year 2020
- Perspectives on Geriatric Medicine
- Progress Report on Geriatric Medicine
- Special Report on Aging 1983
- Age Pages

HOW WE AGE

- Aging and Your Eyes
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- Hearing and the Elderly
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- Skin: Getting the Wrinkles Out of Aging
- Taking Care of Your Teeth

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- Who's Who in Health Care

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- Be Sensible About Salt
- Dietary Supplements: More is Not Always Better
- Hints for Shopping, Cooking, and Enjoying Meals
- Nutrition: A Lifelong Concern

Video Tapes

(Source)	(Title)
University of Southern California USC News Service STO 307 Los Angeles, CA 90089-1141 (213) 224-7041	"Silent Changes in the Brain"
American Journal of Nursing Co. Education Services Division 555 W. 57th Street New York, NY 10019 (212) 582-8820	"Gerontological Nursing Series" (30 minutes)
Hospital Council on Southern California 6255 Sunset Blvd., 8th Floor Los Angeles, CA 90028 (213) 469-7311	"The Geriatric Patient: Effective Management of Behavioral and Mental Disorders" (60 minutes)
Extended Care Specialists Box 24 Evansville, IN 47701	"Please Look at Me" (15 minutes)
Video Services Department of Physical Therapy University of Maryland School of Medicine 32 South Greene Street Baltimore, MD 21201 (301) 328-5497 or 328-7720	"What is Dementia?" (16 minutes) "Solutions for Today" (20 minutes) "Medication and Dementia" (20 minutes) "Nursing Care for Elderly Dementia Patients" (25 minutes) "Caregiving with Grace" (28 minutes) "Caregiver Stress" (25 minutes)

(Source)	(Title)
Roche Laboratories Division of Hoffman-LaRoche, Inc. Nutley, NJ 07110	"Alzheimer's Disease: A Clinical Update" (50 minutes)
University of Michigan 400 Fourth Street Ann Arbor, MI 48103-4816	"Wesley Hall: A Special Life"
	"Designing the Physical Environment for Persons with Dementia" (20 minutes)
	"Helping People with Dementia in Activities of Daily Living" (22 minutes)
Good Samaritan Hospital and Medical Center - AV Services 1015 N.W. 22nd Ave. Portland, OR 97210	"Managing with Alzheimer's Disease" (30 minutes)
	"Alzheimer's Disease: A Family Perspective" (30 minutes)
Alzheimer's Disease and Related Disorders Association, Inc. -- Your Local Chapter (To locate call 1-800-621-8491)	"Caring Families Coping with Alzheimer's Disease" (30 minutes)
Terra Nova Films, Inc. 9848 Winchester Avenue Chicago, IL 60643 (312) 881-8491	"My Mother, My Father" (33 minutes)
WCVB-TV Channel 5 5 TV Place Needham, MA 02192	"Someone I Once Knew" (55 minutes)
Marin Community Video attn: Production Director 61 Tamal Vista Corte Madera, CA 94925 (415) 924-7370	"Women Who Care: Living with Disabled Husbands" (20 minutes)

(Source)	(Title)
Missouri Vocational Resource Center 10 London Hall University of Missouri Columbia, MO 65211	"Sharing the Burden: Meeting the Challenge of Alzheimer's in Local Communities" (60 minutes)

The following video cassettes produced by the Hospital Satellite Network are available for rent from Western Missouri Medical Center. For more information, call Linda Gentry, Continuing Education Director, Western Missouri Medical Center, 403 Burkarth Road, Warrensburg, Missouri 64093; telephone (816)747-3183 or 747-2500.

#0373	Alzheimer's Disease: An Introduction for Caregivers
#0374	Alzheimer's Disease: Home Care and Problem Solving
#0375	Alzheimer's Disease: Alternative Care
#0376	Alzheimer's Disease: Advocacy and Support Groups
#7501	Alzheimer's Disease: Coping with Confusion
#7512	Alzheimer's Disease: Discharge Planning
#8347	Alzheimer's Disease: Effects on Communication
#A5082	Dementia: A Clinical Approach